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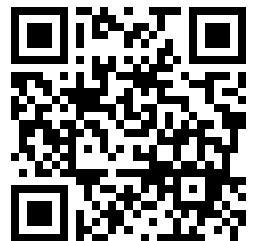
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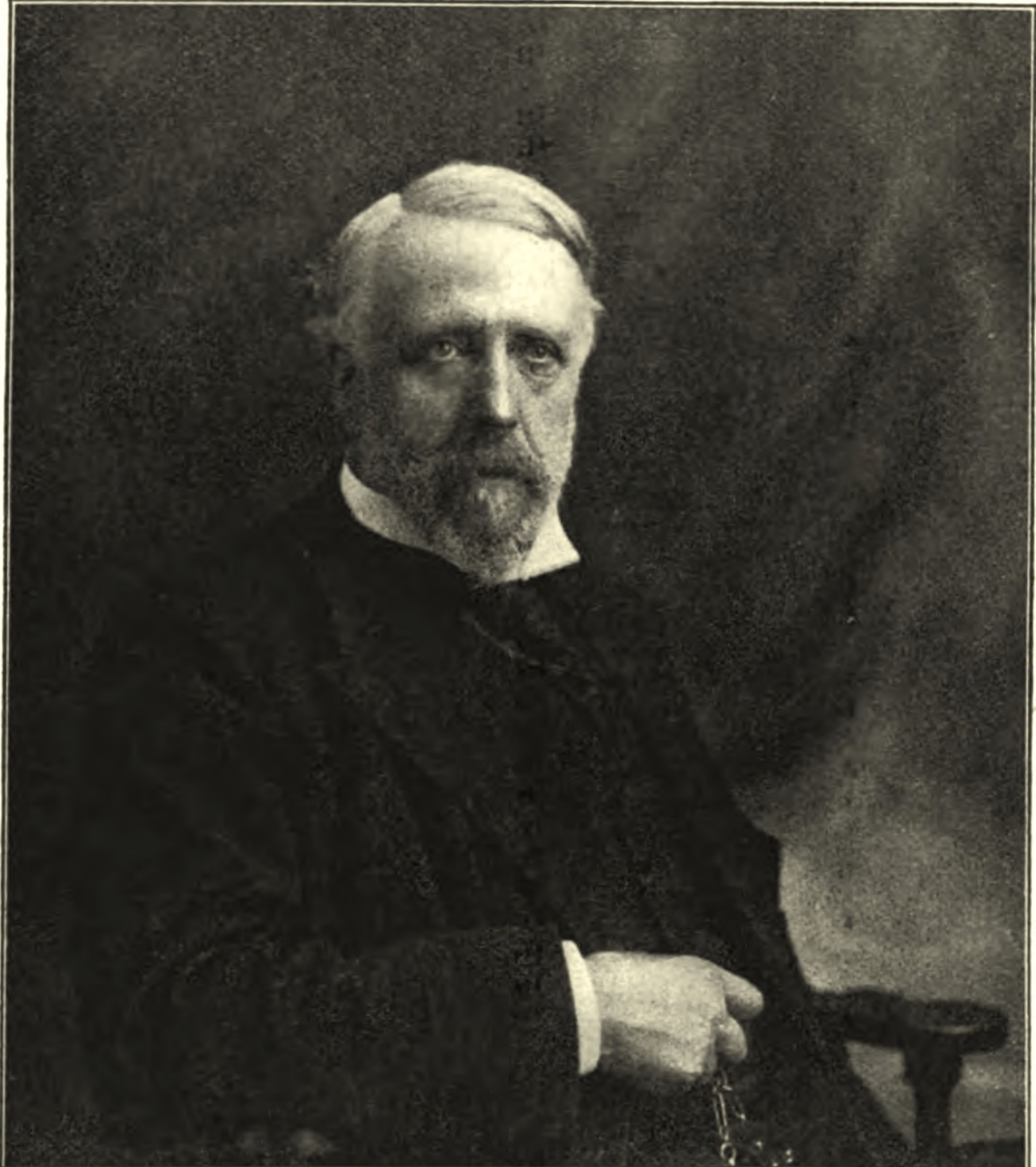
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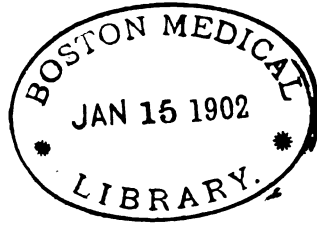
OF

MEDICINE AND MEDICAL AFFAIRS.

FROM JULY TO DECEMBER,

1901.

LONDON: 8 HENRIETTA STREET, STRAND; DUBLIN: 16 LINCOLN PLACE.



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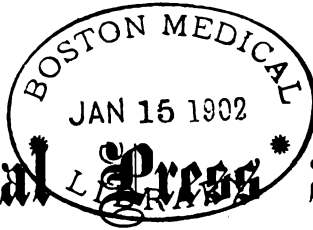
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## The Cabendish Lecture

ON

### ACUTE CARDIAC FAILURE. (a)

By Sir RICHARD DOUGLAS POWELL, Bart.,  
K.C.V.O., M.D.

"ACUTE heart failure" is, I admit, a misleading phrase, suggesting, perhaps, some separate disease of the organ, but of course it only implies the culmination in temporary or permanent arrest of the cardiac function of a variety of conditions damaging to texture and exhaustive to nerve power or muscular energy.

We cannot perceive aright the heart and its mechanism, nor appreciate duly its modes of failure, unless we bear steadily in mind the fact that it is but a part, differentiated for special reasons, of a complete cardio-vascular tubal system containing the blood. The tubes are not passive tubes sluiced by a central force pump; on the arterial side the powerful rhythmic pulsations of the heart are so modified and restrained by the elastic and muscular action of the vessels as to ensure a safe and adequate stream of blood throughout the body. Whilst on the venous side the position of valves, the action of adjacent and often ensheathing muscles, the impetus of lymph and chyloferous tributary currents, and the constant but rhythmically increased thoracic aspiration, help to maintain the blood movement.

I need only hint at the large influence of the nervous system which has in course of evolution become so specialised with regard to the heart and vessels. The cerebro-spinal nerves, the sympathetic system and a department of the nervous system—the vaso-motor nerves—in touch with the preceding and yet under guidance from a separate centre, all take part in controlling the heart's doings and in regulating the blood supply to each organ, according to its functional requirements, which vary from time to time. Finally, there is held in the tightening and relaxing grasp of this complex tubal apparatus, the blood itself, a living tissue, whose constant variations, both chemical and physical, in health and disease, affect the facility of the capillary flow and influence the tonicity and nutrition of the circulatory apparatus. Can we look into this complex mechanism, which I have so barely sketched, in which physical, chemical, and vital agencies are so intimately mingled, without a feeling of wonder that it should hold good unceasingly to the allotted term of life, and that so few lives should be brought to a premature close through heart failure? A chapter on compensatory adaptations has yet to be added to our text books on medicine for our better understanding of many such problems.

With such an infinite number of contributory

factors, acute cardiac failure cannot be a simple question, and if I, bound by the stern limits of time and the more compelling limitations of my ability, approach it from the more concrete, clinical, and practical side, it is from no want of appreciation of the manifold intricacies of the subject, and it is with a very humble sense of our indebtedness as practical men to those who by patient labour in the laboratory have given us so large an insight to help us to solve the problems that come before us in our daily work.

A most obvious cause of heart failure is direct injury, excluding, of course, external wounds, as, for instance, the very rare occurrence in which a healthy man, during some sudden effort, ruptures one of his aortic cusps. The whole cardiac mechanism is suddenly put out of gear, severe præcordial pain disorderly action and faintness ensue, to be followed by other signs of perturbed circulation. In the only case of this injury that I personally remember seeing, almost immediately there was a smart hæmoptysis, no doubt from the over-distended left ventricle obstructing the return from the lungs. Under the only treatment possible—very complete rest—the heart, at first surprised and only very imperfectly able to deal with the altered mechanism consequent upon the spoiled condition of its main valve, gradually steadied down. The left ventricle enlarged and increased in power, and a small, rapid and irregular pulse was gradually altered to that having the characteristic features of aortic regurgitation. This alteration of pulse marked the adaptation of the heart to its new conditions in a manner precisely similar to that which we observe in a case of aortic regurgitant disease, in which dilatation of heart and mitral inadequacy having arisen, the irregular mitral characters of the pulse change under rest and treatment to those proper and normal to a well-compensated aortic regurgitation.

The displacement of a clot from a systemic vein is a common cause of acute anginal heart failure and is attended with urgent dyspnoea, an irregular, fluttering pulse and very variable heart signs. The condition is indeed one of *asphyxia* of the heart, and it either terminates rapidly in death or the clot is further dislodged and propelled into the lung, when the cardiac symptoms quiet down and those of another order commence with hæmoptysis significant of pulmonary infarction. Here again we can only recognise what is happening and relieve suffering and ensure quietude by tubcutaneous morphia. Be it remembered, however, that these cases are by no means necessarily fatal; if the clot passes on to the lungs recovery ensues in a fair proportion, and the prognosis in each case must be considered on its separate merits.

Next to such injuries to the heart, of which I have given right-sided and left-sided examples, we must glance at cardiac failure from over-taxation.

There are two factors always at work, although in

(a) Delivered before the West London Medico-Chirurgical Society on Friday, June 21st, 1901.

different proportions in different cases, in producing cardiac failure from great or prolonged exertion, viz., direct fatigue of the nervo-muscular tissue of the heart and a poisoning of the blood of autometabolic source.

Speaking of young people and healthy hearts, acute cardiac distress is, of course, very common in these days of athletic competitions, strenuous school exercises, hard bicycling, &c. It is indeed surprising that actual heart failure so rarely occurs; but few of us have an opportunity of witnessing such an attack. Fatal cases are rare but have been recorded, but for the most part we can only observe the after effects of incomplete heart failure.

While gentle exercise calculated to raise the blood pressure within the coronary circuit is thus to be advised, caution is necessary that no cardiac fatigue be induced. The periods of exercise should be of short duration. In old people with atheromatous vessels, cramp in the legs is readily induced by any fatiguing exercise, in consequence of the imperfect nutritional change allowed by the narrowed arteries, and similarly we may get cramp in the heart muscle, that is apt to prove fatal. It is also to be noted that the cramp of fatigued muscles does not necessarily come on at once, but is frequently postponed until the night. Many a fatal attack of angina pectoris has thus been prematurely induced by some over-fatigue or excitement in the day.

Among the concomitants of heart disease or failure during violent exercise, as running, vomiting is one of the most common; a boy will tell you that at the end of a long race which has over-taxed him, he will cast himself panting upon the ground and vomit.

Among the after effects one of the most constant is anæmia, and both of these phenomena—vomiting and anæmia—may be regarded as bearing witness to a changed condition of the blood consequent upon the accumulation of products of metabolism which takes a not unimportant part in the mechanism of heart failure. I would remind you that gastro-intestinal attacks, vomiting or diarrhoea, are not uncommon occurrences in those who, habitually leading a sedentary life, suddenly take to exhausting exercise. There are other more certain proofs of altered blood in those who have died from excessive exercise and in hunted animals, of which increased liquidness of the blood, absence of post-mortem clotting and darkened colour are among the more obvious.

In estimating the consequences of over-taxation of the heart from violent or prolonged exertion, in young people especially, there are one or two points of practical moment to be observed. A glance at Beneke's (a) tables will show that the heart of the child is somewhat precociously developed. According to Beneke, whilst the height doubles in the first seven years, the heart volume increases nearly five fold. In the second seven years things go more quietly, the height increasing by one-third and the heart volume by one-fourth, but the practical effort of this developmental activity must continue on through these years.

This cardiac precocity is in accordance with what I believe to be a fact which I have long observed and pointed out in clinical teaching, viz., that the heart of the child—say between six and twelve years—is relatively hypertrophied, i.e., the apex beat is somewhat to the left of the normal and the impulse relatively strong. This is the case especially with boys, and, in my experience, holds good with a considerable proportion of them. I have regarded it as due to the ceaseless activity of children and to a developmental precedence of heart to chest and lung

capacity. The practical point is that I do not regard a slight extension of the apex beat within the nipple line, unaccompanied by confirmatory signs, as necessarily a morbid condition in a child. I look for the evidence of cardiac overstrain rather in an extension of the upper margin of dulness in the mid-sterno nipple line with an unduly perceptible beat at the ensiform base, and a hesitating action of the heart, i.e., an irregularity in rhythm and force. These signs in association with languor, anæmia, breathlessness on exertion, and sometimes a sharp pain at the heart which I have heard described as a "beastly pain catching the wind," caused by a slight effort, are sufficient for diagnosis. You may get others, such as murmurs: you often do get a hæmic murmur over the pulmonary area, but murmurs are by no means essential, or to be expected.

A cardinal point—and the only one I shall touch upon—to be borne in mind with regard to young boys and girls is their special aptitude for short spells of active exercise, but their complete unfitness for prolonged, fatiguing, monotonous exertion. This is almost the reverse condition applicable to older people, and it is one often forgotten, not perhaps so much at schools as at home. Athletic fathers, robust elder brothers, proud of the sporting alertness and eagerness of young boys, will often keep them out on long bicycle, golf, or shooting expeditions, and may thus cause grave damage to the young and rapidly developing heart.

The treatment of acute failure of heart from over-strain involves a period of a few weeks' complete rest and often many months of careful supervision. Young people make a rapid and generally a complete recovery, provided no actual lesion has been produced. The younger they are the more ready and complete the recovery. In youths and young men a degree of irritability of heart is often to be observed for many months, even for some years, the patient suffering from attacks of palpitation and cardiac pain on slight fatigue or exertion and often at night. Quiet exercise must be resumed after a time, and it is, in my opinion, better to allow interesting exercises, within measure, such as croquet, level cycling, golf and easy tennis, rather than more formal courses of training. But each case must be considered on its merits. In some cases of cardiac overstrain in young people it will be found that a feeble lung capacity has led through imperfect pulmonary circulation to the heart distress. In such cases well ordered respiratory exercises will best help the heart by developing the lungs and fortifying the thoracic aspiration in aid of the circulation. Well-planned sea voyages or sailing trips from the coast are peculiarly advisable for adults, provided strict injunctions against smoking and all strong alcoholic drinks are given.

Another form of fatigue heart failure is that frequently met with in acute disease. It is too long a story for me to go fully into now. I have dealt with it with some minuteness elsewhere, (a) as met with under one of the most common of circumstances, viz., in acute pneumonia. It is met with also in enteric fever, in acute bronchitis in old people, during a severe asthenic paroxysm and in other conditions, such as functional tachycardia. The heart failure in these conditions may come about with a gradual quickening day by day of the pulse until it becomes fluttering, confused, running, representing little more than peristaltic movements of the heart. In other cases, and this more commonly in plethoric, fleshy large-framed people, with a pulse at first not unduly quick, with considerable tension and accentuation of the second sound, the failure occurs quite

(a) "Die Altersdisposition," 1879, p. 94.

(a) Lumleian Lectures. "On Treatment in Diseases and Disorders of the Heart," Lecture iii.

suddenly, attended with rapid breathing, pallor and cyanosis, sweating; collecting mucous rattles in the chest and almost imperceptible running pulse. Under strong stimulation and the subcutaneous use of strychnine, the patient may rally and all the conditions improve, but relapse often, and in elderly people almost always takes place. An attack such as I speak of occurring in an old person with bronchitis or pneumonia is almost of fatal augury; the senile heart cannot recover the fatigue, and hence when the pulse mounts up to 120 in old people recovery is rare, unless the rapidity be attributable to functional disturbance from some temporary cause. With a sound heart in younger people no condition is too desperate for possible recovery.

Now to discuss the treatment of heart failure under these varying circumstances would be to discuss the whole management of the illnesses in question. There are a few factors, however, in special concern with heart failure in acute disease, which should be looked for as indications for treatment, viz., (1) maloxxygenated and otherwise contaminated blood supply to heart muscle and nerve; (2) excessive weight of blood burdening the heart; (3) exhausted innervation from sleeplessness and physical cardiac fatigue; (4) positive obstruction to the flow of blood through the lungs; and (5) changes in the texture of the heart muscle incidental to the disease and especially to the pyrexia. Now the first two indications are undoubtedly met by depleting the blood volume from the venous side by attention to secretions, the occasional use of mercurials, careful limitation of the food taken in place of the over-feeding often to be observed, and in some cases a small blood-letting. The timely employment of oxygen inhalations at intervals through the day is a remedy of great value which ensures an improvement in the aëration of the blood sent to the left ventricle, and so direct to the coronary vessels. It is by no means necessary to employ oxygen inhalations in the majority of cases of pneumonia, of which disease I am now especially speaking, but in all severe cases the cylinder should be at hand to anticipate the threatened heart failure.

No. (3) and (4), exhausted innervation and pulmonary obstruction are met with in pneumonia, advanced typhoid and asthenia especially. Strychnia is the most powerful cardiac tonic we know, and subcutaneously used is the best remedy for heart failure. In these cases, however, a frequent concomitant symptom is ballooning of the abdomen, and it is both dangerous and inefficient for the purpose required, to give strychnia in such cases by the stomach. In asthma, pneumonia, and in enteric fever, it is often possible in combination with the free use of oxygen and the occasional injection of strychnia to give a sufficient subcutaneous dose of morphia to procure much-needed sleep. When the heart threatens to fail in asthma the paroxysm must be thus shortened. In bronchitis, on the other hand, under no circumstances can morphia be so given. I have often observed cardiac exhaustion threatened in asthma through the want of small administrations of concentrated and assimilable food essences at intervals to support the patient. Alcoholic stimulants are, of course, often necessary, the dose being adapted to suit the individual case. (5) The changes incidental chiefly to pyrexia in the heart muscle as a cause of failure are mostly to be considered in the prolonged fevers and will be best warded off by a judicious mitigation of the pyrexia. I would only observe on this head that in cases where there is labouring action of the heart and a tendency to cyanosis and stagnation of surface blood, I have observed much better results from hot water than from cold water sponging or cold applications. The surface circulation is more facilitated, heat is rapidly

lost and the skin functions encouraged, all tending to lighten the burden of the heart. In the after treatment of pyrexial diseases, in which there has been prolonged rapidity of heart or any sign of heart failure, a chief regard has to be paid to restoration from cardiac fatigue. Thus our level sea and country resorts are preferable to hilly places, and exercise can only gradually and tentatively be resumed.

I can only glance at specific poison failure of heart in diphtheria, phosphorus poisoning, malignant anæmia and the like, in which the cardiac nerves are directly poisoned, and in most cases a rapid fatty change in the heart fibres ensues. These cases are mostly fatal with the exception of the influenzal cardiac affections among which symptoms of slowing and increased rapidity of heart are met with, also some most intense forms of angina, usually vasomotor, and attacks of dangerous syncope may occur, yet the prognosis is, even in severe cases, so far as my experience goes, as a rule, favourable.

Of angular heart failure I have no time to speak at length. I would only urge that from a treatment as well as from a scientific point of view, we must regard angina pectoris as in the largest class of cases a functional disease—a cardio-vascular neurosis. In many cases it is dependent upon disorderly action of the vasomotor nerves, and is associated with a sound heart (*angina pectoris vasomotoria*). In many other cases we have a similar mechanism, but with, in the background, an unsound heart—aortic regurgitation, aneurysm, senile fibro-fatty hypertrophy, coronary disease and the like (*angina pectoris gravior*, or secondary cardiac angina). In numerically a comparatively small class the angular failure is the consequence of cardiac degeneration, secondary to coronary disease, sometimes to coronary thrombosis or syphilitic disease, viz., syncopal angina or primary cardiac angina.

It is obvious that all the causes of excitement, direct and reflected, of the sympathetic and vasomotor nerves must be looked into in dealing with the larger proportion of these cases, whilst on the other hand, any special form of cardiac lesion must be appropriately dealt with. In accordance with what has been above stated, the immediate remedies for the cardiac attacks are, in the majority of cases, of the antispasmodic and sedative class, amyl, trinitrine, opium, directed against the arterial spasm, which is so important a factor in the attack. When we are assured of the presence of coronary lesion, the employment of regulated exercises, combined resistance and respiratory exercises, and, in old people especially, the regulated use of oxygen inhalation will help to maintain cardiac nutrition for at least a time longer.

There are two conditions leading up to heart failure which I have not touched upon, and yet which, from the remedial point of view are of immense importance, but they have been fully handled by my colleague, Dr. Mitchell Bruce, in his recent Lettsoman Lectures. One is typified in the middle-aged, plethoric man who, working hard, lives too well and takes little exercise. This man gradually acquires a fatigued and over-burdened heart, over-weighed with the heavy volume of blood it has to propel. He may get a spring or summer cleansing once a year at Homburg, Harrogate, or Carlsbad, with no intermediate precautions he drifts along often into irremediable disease of heart, or kidneys, or both. His first introduction to the physician is often after an attack of breathlessness and cardiac excitement, or failure occurring on some unwonted exertion, after which he remains perceptibly short-breathed. His cardiac area is extended, partly from a slight yielding, but mainly from præcordial and interstitial fat. The first sound is weakened often to extinction, the

second sound labouring; there may be slight albumen or a little sugar in the urine. If taken in time and placed under fluids taken chiefly between meals, a great curtailment of alcohol and smoking, and well arranged exercise, with insistence on deep, full inspirations from time to time whilst walking in the fresh air, such a man will be restored to health and practically rescued from some early catastrophe in the form of heart failure, in acute illness, or from drifting into chronic cardio-vascular disease. A few weeks' change away whilst getting inured to the treatment is of great value, and such cases will derive especial benefit from Nauheim or modified Oertel treatment.

The other class of cases I would refer to in association with two causative factors, viz., nicotine and epilepsy. I may bring my remarks to a point and a conclusion by a brief sketch of a case in illustration.

A captain in an infantry regiment was invalided home from South Africa, on account of attacks of heart failure. He was a married man, *æt.* 37, had never had syphilis, but was an inveterate cigarette smoker, and a little free with alcohol. In July, 1900, while mounting a hill he felt distressed, and on return to camp fainted, and after this he was unable to exert himself without some distress. In September, having escorted some prisoners from Durban to Cape Town, without sickness or fatigue or any hardship, he on arrival was about to get ready for dinner and in the act of taking a glass of wine bitters, when he suddenly fell down unconscious and pulseless, so that a doctor who saw him immediately thought him dead. He remembered nothing until he woke at 2 a.m., feeling very faint and ill. There was no preceding sense of faintness, no pain and no convulsion. On a later occasion, while feeling very well he suddenly fell unconscious for a quarter of an hour. He has had one similar attack since his return home in November. He was subjected to a course of Nauheim treatment without benefit. His complaint was, besides these attacks, of almost daily attacks of cardiac pain, especially induced by any exertion. Dr. Walker, under whose care he came subsequent to the Nauheim course, by rigorously restricting the tobacco and regulating his diet and stimulants, materially relieved these symptoms, and when I saw the patient with Dr. Walker in April the cardiac dimensions, position and sounds were normal, and the pulse, although feeble and rather quick, presented no other special feature. On inquiry into this gentleman's family history nothing cardiac was elicited, but it was ascertained that his brother was a deaf mute and his second son was the subject of very frequent and severe attacks of *petit mal*. This case was primarily, no doubt, one of angina heart failure in association with excess in nicotine, and as such belongs to a class of frequent occurrence, but the instantaneous attacks of unconsciousness were suggestive of at least an associated neurosis of an epileptic character. I have met with one other very strikingly similar case in a younger man, also an excessive smoker, and I have a less full recollection of another case in connection with excess in cocaine.

I have from time to time been consulted about a lady who has long been the subject of night attacks of an epileptic character, and who has recently developed marked and rather severe attacks of angina, with heart failure of an alarming degree, many of which attacks usher in a mild epileptic seizure. In her case the pulse of late years has become extremely slow, and she has presented some symptoms of myxœdema. It is remarkable that in this case the amyl class of drugs are useless, but strychnia gives immediate relief both to epileptic and cardiac phenomena.

Cases of cardiac hesitation with pulse of uneven

rhythm, not amounting to intermittency and presenting occasional attacks of fainting, are not very infrequent among children, young boys, especially between the age of six and puberty. They are easily tired, and are generally anæmic. It is quite exceptional to find them addicted to any secret vice. There is nothing abnormal beyond altered rhythm and vacillating force to be found in the heart. The distinction between this form of heart failure and *petit mal* is often difficult, and I am strongly inclined to regard the two conditions as allied. Removal from any mental pressure, an outdoor life and arsenical tonics, generally result in gradual recovery.

I have endeavoured in this address rather to suggest lines of thought and methods of treatment, feeling that you are as competent as I am to give a practical therapeutic interpretation to whatever of my suggestions may meet with your acceptance.

### THE "MONOMA." (a)

By HERBERT SNOW, M.D.Lond., &c.,  
Senior Acting-Surgeon, Cancer Hospital, Brompton.

I HARDLY think any one will dispute the claim of our former President, the late Mr. Lawson Tait, whatever may have been his personal defects, to be regarded as the most original and brilliant gynecologist of modern times. One of his most important contributions to that science seems to me in some risk of oblivion, at least, I do not remember any allusion to the point since the publication of his work. And although the case I have to report was unfortunately not successful, I feel sure that apart from its own intrinsic interest, the Society will approve of anything tending to rescue a question of much practical significance from unmerited neglect.

It will be remembered that Lawson Tait's experience led him to distinguish, and to insist strongly, on the clinical difference between two species of uterine myoma. He laid down two fundamental distinctions to begin with. The ordinary prevalent fibroid tumour is generally multiple when first encountered; and, if not, speedily so becomes as time advances. The rarer, the "soft œdematous myoma," is invariably a solitary tumour, and remains single to the end. In the second place, while the former may never attain any considerable size, and may even diminish in bulk after the menopause; the latter always steadily continues to increase until the patient is "released by art or removed by death." That is to say in other words, while the common myoma is a benign new growth the rarer "soft œdematous myoma" is one truly malignant.

Then Lawson Tait further drew certain minor distinctions, into which I am not sure we can unreservedly follow him. Thus he stated that removal of the appendages promptly terminated the growth, and the attendant menorrhagia of the common myoma, while that operation had no effect on the rarer variety. The former arises only during the menstrual epoch, the latter prefers the old, though, as in my own case, it may begin earlier. The ordinary myoma tends to diminish in bulk after the climacteric; the latter is wholly unaffected by this. The former often involves menorrhagia; the latter is rarely attended by undue loss of blood per vaginam, and has no influence whatever on the menses.

One of Mr. Tait's cases ultimately involved a livid protrusion through the umbilical aperture. I had an opportunity of examining microscopic sections from two others. One showed only non-striated muscle-fibre; the other, the abundant nuclei and small spindle-cells which denote a myo-sarcoma. In

(a) Paper read at the British Gynecological Society, June 18th, 1901.

such matters, as I have often insisted, the clinical evidence of malignancy is far more trustworthy than the report of a microscopist who has never seen the case. The malignant process is commonly limited to certain areas, which may be neglected when a thin section is cut for the microscope; or may escape notice even when therein included.

The following is a brief note of the case in question:—

Lucy J., *æt.* 47, married, but for several years separated from her husband, was admitted into the Cancer Hospital, November 27th, 1900. She had previously, in 1895, undergone an operation there for cystic degeneration of the mamma. Since then there had been menorrhagia. There had been one child born at full term, one miscarriage, one premature birth. Had noticed enlargement of the abdomen one year. Has lost much weight in the past eight months, though still stout and rather flabby-looking. At the menstrual periods there is much pain, but that has always been the case. The loss, however, is "like that of a confinement."

The abdomen was found distended by a central round mass, mobile, exhibiting ill-defined fluctuation like that of a tense cyst. A consultation of the staff was held according to rule, and while the majority regarded the tumour as solid the possibility of a thick-walled ovarian cyst was admitted.

Abdominal hysterectomy, after Dr. Heywood Smith's method, was performed on November 30th. The divided cervix proved exceptionally vascular. On the following day all was well, as the temperature chart sufficiently indicates. There was no vomiting, and not even a headache. And here I cannot forbear quoting the acute remark subsequently made to me by the excellent nurse in charge of the case, that "she was always better pleased when they vomited well after an abdominal operation, for otherwise it seemed as though they had to get rid of the bile afterwards, and were thus thrown back."

On the morning of the second day an enema of glycerine and peppermint water was given according to my invariable rule, and the bowels acted freely.

On the afternoon of the third, going into the ward, I found that the abdomen was distended and that the patient was vomiting. Another enema was immediately ordered. The bowels acted, the patient passed flatus, and felt much relieved.

At about four o'clock on the following morning, however, she again began to vomit, and this time the ejecta were *fecal*. I was sent for at eight. Another enema was administered, and preparations were made for re-opening the abdomen. The patient, however, sank rapidly, and died at 12.30.

At the autopsy was found enormous distension of the stomach and intestines; with two perforations of the ileum about ten inches above the ileo-cæcal valve. The peritoneum was perfectly healthy, and all the surgical conditions in every way satisfactory. No adhesion, kink, or other source of obstruction could be detected. There were three inches of fat on the abdominal wall; a condition pointing, I think, to rather free indulgence in alcohol, which I regard as militating strongly against recovery in such cases.

It must surely be an almost unique event for a not aged woman to go on for several days after a *cœliotomy*, having her bowels well moved more than once, and then to collapse suddenly from intestinal distension and rupture, without any mechanical source of obstruction whatever.

The microscopic section exhibited shows, over almost the whole area, the organic muscle-fibre of an ordinary myoma. A very minute region, however, displays the heaped-up leucocytes and abundant cell-proliferation denoting a cancerous degeneration.

Apart from the very unexpected and peculiar ending, I should direct the Society's attention to the following points:—

I. The existence of this progressive and malignant growth, for which I venture to propose the new term, "Monoma."

II. The importance of differentiating it from the comparatively harmless myoma, by this or some other distinctive word. For, here, there can be no question of tentative measures or of delay. The disease is malignant, and once recognised should be immediately removed.

III. The important question of diagnosis, hitherto neglected, and as yet unsettled. The presence or absence of vaginal hæmorrhage, as insisted on by Lawson Tait, is untrustworthy. With that event alcoholic habits have much to do. Age also is an uncertain factor.

If we encounter a solitary rounded, *doughy*, central uterine tumour which is growing rapidly, while the patient is losing weight, if we find an indistinct fluctuation, so that we doubt whether it is not an ovarian cyst we are dealing with, and if there has been much recent trouble and anxiety, then I hold we are justified in diagnosing a Monoma, and in advising prompt excision.

To the naked eye the tumour will, after removal, present a superficial resemblance to the common benign form. But its solitary condition, if any size has been reached; the division of the cut surface into lobules, between which are connective-tissue trabeculae infiltrated with serum; the presence of soft areas, into which one can easily push one's finger; the greatly hypertrophied uterine wall, simulating pregnancy; differentiate it.

Under the microscope the malignant portions will show very numerous leucocytes, with cancerous proliferation of the muscle-nuclei; while the non-malignant will display only the phenomena of well-organised muscle. But here special supervision must be exercised over the proceedings of the pathologist. Otherwise the section will probably be taken from the tough, well-organised areas; while the softer and more vascular, upon which the accuracy of his report will mainly depend, are prone to escape. I fancy the thin section here exhibited, and over the cutting whereof no such supervision took place, will exemplify the error which might so readily arise. For you see only a very minute portion of malignant tissue at one edge of the section, its bulk being composed of well-organised muscle-fibre.

## TWO CASES OF SYPHILIS WITHOUT PRIMARY LESION.

By Dr. L. JULLIEN,

Surgeon to the St. Lazare Hospital, Paris.

CLINICAL experience sometimes throws more light on morbid processes than experimental observation. The cases which I am about to relate are in contradiction with generally received views, but they are so well authenticated and so unquestionable, so closely in accord moreover with modern ideas on the evolution of the virus, that we can only bow to facts and record them for the benefit of our theories.

On June 9th, 1899, two medical men, a surgeon and his assistant, operated on a woman for a præsternal tuberculous tumour. After excising the tumour and scraping the base, they proceeded to insert the sutures. The needle did not work very well, and the surgeon, in endeavouring to withdraw it from the edges of the incision, ran it deeply into the end of his index finger. The needle being flat, with sharp edges, made a rather extensive wound which bled freely. His assistant, in

repeating the manoeuvre, did exactly the same thing and wounded himself in the same place. On June 17th, on changing the dressings for the first time they noticed a slight ulceration with bright red edges at the orifices of entry and exit of each suture. These appearances suggested the idea of syphilis, of which nothing in the patient's history had previously transpired. On the following day she developed a generalised roseola, and on examining the genital organs they forthwith discovered a syphiloma in the region of the fourchette, undergoing cicatrisation. The inguinal glands were enlarged.

On July 5th, twenty-six days after the inoculation, the surgeon was suddenly seized with fever, shivering, and a general feeling of discomfort, and kept his bed for twenty-four hours with a temperature of 39° C. (102.2° F.). At the same time the site of the puncture became painful, the end of the finger became swollen, and the scar of the puncture displayed a tendency to reopen with some trifling superficial ulceration. On the thirtieth day a roseolar eruption made its appearance. On July 16th the scrotum became covered with moist papules, and two days later *plaques* formed on the tongue. He then began to complain of arthralgia, which, throughout the month of July, rendered the loins and wrists painful. On the 26th we noted palmar papules, since which time the disease has followed its implacable course, though in a mild form.

The assistant displayed no sign of infection until the thirtieth day, but on July 9th he, too, was seized with fever. Nothing abnormal was at any time noticed at the site of inoculation, the scar whereof remained intact, and the roseola did not appear until the thirty-third day. I need not go into the details of the subsequent history of the attack, which followed the usual course. I wish, however, to insist particularly upon the conclusions which we are justified in drawing from these data, conclusions which are fairly obvious.

1. The blood of a syphilitic subject is infective, a fact with which Pellizzari had already acquainted us, but we did not know for certain the epoch at which it becomes infective. The present observations prove that the infectivity exists prior to the occurrence of the secondary symptoms, since the surgeon and his assistant were inoculated nine days before these made their appearance in the patient. Assuming an average period to have elapsed between the primary lesion and the secondary symptoms, the patient must have had her chancre some thirty days before.

2. In these two cases the inoculation accidentally took place into the blood itself, and the evolution of the disease skipped the stages which usually give time for a focus of infection to develop at the point of inoculation, giving rise to a syphiloma, thus impregnating the lymphatic system, which is always the first to suffer. Here the lymphatic period is done away with, the organism is taken by assault, without being enabled to avail itself of the glandular barriers, which are swept aside from the onset. As a matter of fact our *confères* sought in vain for evidence of glandular enlargement in the areas corresponding to their wounds. The glands only became perceptible at the period of efflorescence, concomitantly with the mucous manifestations, whence the early supervention of the constitutional manifestations.

This mode of invasion of syphilis, which was theoretically studied by Professor Oltramare, of Geneva, and was clinically demonstrated by Verchère, of Paris, who only succeeded in obtaining the recognition of his cases with considerable difficulty, has never, to my knowledge, received such conclusive confirmation. I need hardly insist on the

far-reaching importance of these observations both from the purely practical and scientific points of view, and I thank my unfortunate *confères* for having permitted me to take careful notes of the details.

## SYPHILIS AS A NON-VENEREAL DISEASE: WITH A PLEA FOR THE LEGAL CONTROL OF SYPHILIS.

By L. DUNCAN BULKLEY, A.M., M.D.,

Physician to the New York Skin and Cancer Hospital; Consulting Physician to the New York Hospital, &c.

ADVANCING civilisation has recognised one after another of the contagious or infectious maladies which afflict mankind, and the arm of the law has come in to protect the defenceless, and we no longer have the wholesale sweep of epidemics which occurred before health boards were organised and given control of these matters. This is often accomplished at the sacrifice of the comfort and, it would often seem, the rights of individuals; but the principle of the "greatest good for the greatest number" prevails, and those who unhappily may become afflicted with any of the maladies coming under the jurisdiction of the health boards are often obliged to sacrifice all personal interest for the benefit of those around them.

Why is it that syphilis, which has always been recognised as an intensely contagious disease, in certain of its stages and manifestations, has, to such a great extent, been allowed to pursue its unbridled course, attacking alike the innocent and those guilty of sexual transgression? Why is it that thousands, yes hundreds of thousands of innocent and trusting wives and helpless and blameless children have had to suffer for the sins of others? Why is it that syphilis has thus been allowed to spread its ravages unchecked by the hand of advancing science and broad philanthropy?

I need not answer these questions, for I am convinced that all my hearers know full well the reason. But, thanks to the light of accumulated knowledge and experience, the shame which has too often checked discussions of the subject, and hampered the efforts of many who, from time to time, in various countries, have tried to stem the tide of this disease, need no longer have an influence. I hope to give you facts and show you reasons which will make every one present feel and know that the disease (syphilis) should and must now have a check put upon its ravages—and my plea will rest, as the title of my paper indicates, upon the vast "army of innocents" who plead for protection from a disease which may attack them when least expected, and may often extend its malign effects through years, and even to succeeding generations.

It is not a little interesting to note that when the disease burst out with such frightful severity in the years 1494 and 1495, at a date closely following the discovery of America, and about the time of the invasion of Italy by Charles VIII. of France, it was not by any means considered as a venereal affection, but spread so greatly among families and in neighbourhoods that it was regarded as a form of plague; many laws were therefore enacted for the protection of the community against what was considered as a new disease which had appeared among them. Also later, even in the sixteenth and seventeenth centuries, we find laws regarding those afflicted with syphilis, prohibiting them from the use of public baths, and even preventing them from coming into general assemblies, &c., and some of the measures taken to hinder the spread of the disease were harsh in the extreme.

I will not attempt, in any way, to go into the legal aspect of the case, either historically or practically, for time and space would fail me on an occasion like this; legal action will follow when once the public is convinced that there is a danger which can be thus avoided.

Mention was made of legal restrictions of the disease

exercised long ago, in order to call attention to the fact that when syphilis was regarded as a general malady not necessarily connected with the sexual act, there was great attention paid to its control; but now, in later years, since it has been regarded more and more as a venereal disease, it has been ignored and left to pursue its destructive way unchecked by sanitary control. The height of the folly culminated in the silly agitation in England which terminated in 1891, with the repeal of the "Contagious Diseases Acts," which had wrought such beneficent results from 1864 till 1881.

As already intimated, the pendulum of knowledge has swung the other way, and during the last twenty-five years or so, a mass of facts has been steadily accumulating, which again calls attention to the aspect of the innocent infection by syphilis, and which demands that the thoughts of those who make laws for the protection of the public shall be again turned to the disease. The data referring to this "Syphilis in the Innocent," the present writer has been collecting for the past ten years, and has recently embodied in a volume, to which further reference will be made in our discussion of the subject.

The basis of our present argument is as follows: as long as syphilis is regarded exclusively as a venereal disease, it is and will be extremely difficult to obtain adequate legislation for its control; whereas, if it can be shown to be one from which the general and innocent public should be protected, there will be little difficulty in meeting and solving the question; it is the hope of the writer that the present paper, with the discussion which may follow, will be the means of such agitation as will result in the ultimate adoption of laws which will in a measure control syphilis in this country.

In order, therefore, to properly understand and appreciate the task before us, it will be necessary to enter into some details in regard to the present extent of syphilis, its modes of propagation in times past, including many episodes which were called epidemics, on account of the large numbers innocently affected in a brief period, and finally to the modes of propagation of the disease in late years, by other than unlawful venereal acts. These matters I will endeavour to present as concisely as possible.

#### WORLD-WIDE DISTRIBUTION OF SYPHILIS.

A word first in regard to the general distribution of syphilis in the world. Many have written from time to time as to the antiquity of syphilis as a disease, even from the most ancient times, and bones exhumed here and there have seemed to show that it has prevailed for ages, as also records in Chinese literature point back to its existence at least 2,000 years B.C. But for practical purposes, most studies of syphilis go back only four hundred years to the period mentioned, 1494 and 1495, and as all know, it was charged that the followers of Columbus brought the disease to Europe from the western lands. Since 1494 the disease has spread, apparently *de novo*, until now, according to the best writers, there is hardly a portion of the inhabited globe where it does not exist with more or less virulence. It is stated that in Russia at least one-quarter of the inhabitants in some villages are infected, and all writers agree that there it is mostly spread in an innocent manner, mainly in family life, as will be mentioned later, for prostitution is almost unknown in the villages.

In Great Britain and Ireland it prevails widely in the great cities and ports, favoured by the neglect of all restrictions on prostitution. Dr. Holland in 1854 estimated that in the United Kingdom there were at least a million and a half persons infected with syphilis each year.

Japan and China are so full of it that Dr. Eldridge states that it is very exceptional to meet a male Japanese who will not acknowledge that at some time he has had syphilis, and in the French Hospital at Tien-Tsin, China, almost 30 per cent. of all cases were of this disease. Time fails even to touch on its prevalence in various other countries, but as stated before, syphilis exists almost universally, and, according to the best authorities, it is steadily on the increase.

There are no data to determine the extent of its pre-

valence in the United States, but any one familiar with dispensary and hospital work in this country will vouch for the very great amount of it seen in daily life. The statistics collected by the American Dermatological Association, relating to some 300,000 cases of skin disease, give a percentage of 11.5 due to syphilis. Some years ago Dr. Sturgis collected the returns from the public institutions in New York City, and estimated that the numbers newly infected there with syphilis could not be far from 50,000 each year.

Time would fail me even to hint at the mass of material which has been brought to light in regard to the modes and methods by which syphilis has been innocently given to individuals, even up to the present time, and often in spite of great care being exercised.

The three great classes or divisions of the subject to which I wish briefly to call your attention are: 1, marital syphilis; 2, hereditary syphilis; 3, extragenital, innocent syphilis.

#### MARITAL SYPHILIS.

The subject of marital syphilis has been very fully discussed by a number of writers, and all acquainted with the subject know well that this mode of infection stands prominent in connection with the innocent acquiring of the disease. While men occasionally contract syphilis innocently in lawful wedlock, even indeed from wives who have acquired it in nursing a syphilitic child, or in some other innocent manner, it is principally the wives who suffer, from the sins of their husbands, before or after marriage, and on them falls a large share of the burden of "innocent syphilis."

Fournier, of Paris, recently made some studies from the cases of syphilis coming to him in private practice. He found that fully 25 per cent. of all females whom he had seen in private practice had contracted the disease innocently and undeservedly, and in the discussion of his paper, Ricord thought that that proportion was too low. Of the married females in Fournier's practice, he found that in 75 per cent. of the cases the disease was unmistakably traced to the husband. In my own private practice I found that in fully 50 per cent. of the females the disease was acquired in a perfectly innocent manner, while among the married females the percentage of innocent infections would be 85 per cent., or more. Surely, then, there is reason in the plea that something should be done to prevent the wholesale infection of these innocent victims of marital syphilis. But if this aspect of the subject is dark, that of hereditary syphilis is yet darker, and calls even more strongly for relief.

#### HEREDITARY SYPHILIS.

The literature of hereditary syphilis is very large and the facts related to it are well known to the profession. Time and space will allow of but the briefest mention. We may for a moment first refer to the effect of the poison upon the viability of children born of syphilitic parents. I cannot do better than refer to some very striking tables given by Sturgis in an appendix to Diday's work on "Infantile Syphilis." They are from the records of births of syphilitic children at the Moscow Hospital, Russia, from 1860 to 1870. During these years there were 2,002 such births, and 1,425 deaths; that is, 71 per cent. of the children born there of syphilitic parents died. Other writers are in accord as to the very great death-rate among those born of syphilitic parents.

It is to be remembered also that syphilis is the cause of innumerable abortions, and also produces sterility, both in the male and female. If, therefore, the effects of syphilis were limited solely to destruction of life in the newly-born, or in the products of conception, there would be a strong reason for the introduction of measures to check the spread of the disease, from its loss of life to the state. But this is only a portion of the ills wrought by syphilis in connection with generation, and it would be better that children of syphilitic parents should thus fail of life, rather than be born with an inheritance which often proves a curse.

#### EXTRAGENITAL SYPHILIS.

The third division of our subject, namely, extra-

genital infection, or syphilis acquired quite apart from any sexual relations, is one of the most interesting lines of investigation possible, and has been illustrated by thousands of recorded cases, reported by many hundreds of observers. I may remark that nearly 200 cases of this kind have fallen under my own personal observation and care. A slight classification of the facts may help us to a better understanding of the vastness of the subject, and its very, or most, important bearings upon the health of the community and the dangers from syphilis.

The cases referring to the different methods of acquiring syphilis accidentally, apart from sexual life, as actually observed at the present time by every one who has opportunities and experience in this line, may be grouped under three main catalogues: 1. Those relating to domestic and industrial life. 2. Those relating to the nourishment and care of children. 3. Those relating to professional pursuits in the care of the sick.

Under the first class we find the instances of transmission finally classified into almost fifty groups, relating to the most different phases and aspects of domestic and social life. Not only has syphilis actually been given by spoons, knives, forks, cups, glasses and jugs, but it also has been communicated by tobacco pipes, cigars, cigarettes and even by troches or candy passed from mouth to mouth; also by shirts, drawers, masks, plasters, bandages, lint, towels, sponges, combs, tooth-brushes, syringes, sick-chairs, &c. Among those who have acquired it in industrial life, that is, innocently in connection with their occupation, we may mention glass-blowers, assayers, weavers, musicians, conductors (by whistles), servants, cooks, furriers, upholsterers, shoemakers, and others.

The second class, representing syphilis acquired through the nutrition or care of children, includes literally thousands of cases where the disease has been innocently acquired by suckling syphilitic children at the breast, and innumerable cases where the nurses and attendants have acquired it by contact with the syphilitic secretions of infants and where diseased children have communicated the disease to each other.

In the third class, relating to professional body service, in connection with the care of the sick, we find three divisions: (1) where the operator is the victim; (2) where the operator is the syphilitic, or gives it from himself to a patient; and (3) where the operator is the medium of conveying the disease from one patient to another.

Under the first class we find hundreds of cases where physicians, surgeons, and midwives have become infected in the practice of their calling. Large numbers of cases are on record where breast-drawers and wound-suckers have acquired the disease.

In the second class we find many records of those who have had syphilis giving the disease to others by body service, as in tattooing, circumcision, vaccination, &c.

In the third class the operator acts as a medium, conveying the poison from one patient to another. Here we find a sad array of cases of infection by skin-grafting, vaccination, through dental instruments, by wet-cupping, the use of the Eustachian catheter, &c.

#### LEGAL CONTROL OF SYPHILIS.

I have thus hurriedly, and necessarily very briefly, run over a few of the points relating to our subject illustrating the propriety of my "plea for the legal control of syphilis based on its frequency in the innocent"—the details necessary to a full understanding of it would take many, many pages, and occupy as many hours. I beg now to present a brief argument for, and a statement of the method and mode of, the legal control of syphilis which I think feasible at the present time.

From what has preceded it is readily understood that syphilis is a disease which inflicts great injury upon the public health; for it imperils not only those who have been guilty of sexual transgressions, but also those who are quite innocent, and it is upon the basis of protection for the latter that I believe action should be taken.

While syphilis occurs most frequently as a "venereal disease," its prophylaxis or legal restraint by no means

relates to the restriction of venereal diseases; the limitation of the spread of syphilis should be considered from a much broader and higher standpoint, namely, from that of defending the public health and that of individuals against a malady which affects the innocent and guilty alike, and which comes to the innocent not only when its dangers are anticipated, but also when they are least suspected.

In the matter of legal protection against syphilis, therefore, the subject of prostitution becomes a secondary consideration. The question is not one of "regulating prostitution," or of inspecting, licensing, or legalising the "social evil," or of protecting those engaged in it. We approach it from a higher ground, and seek to have some restriction put on a disease which is dangerous and communicable, and which might at any time attack any one in a wholly innocent and unexpected manner. That the spread of syphilis can be checked is self-evident, as has been conclusively proved by the fact that all the epidemics to which reference has been made were averted when the cause was recognised and sufficient measures introduced to prevent the further transference of the poison from one person to another. It is also abundantly shown in certain instances where foreign governments have in some places enforced stringent measures looking in this direction.

We know positively that the poison does not and can not develop *de novo*, but that it is always communicated from one individual to another. We know also that within a certain period syphilis ceases to be contagious in each individual; so that if no new infection is introduced into a community, and the members of that community are guarded against acquiring the disease from one already infected until that safe period is reached, the malady will cease to exist.

Such precautions are exercised both by the public and by individuals against other contagious diseases, such as small-pox, scarlatina, measles, diphtheria, yellow fever, &c., is it not eminently proper that syphilis should be placed in the same category, and protection should be afforded to the innocent against it? Syphilis counts its victims, guilty and innocent, by thousands where other diseases count hundreds. More deaths are ultimately caused by syphilis than by small-pox, while the injury to health, and interference with life work is infinitely greater in the former than in the latter. The conclusion is absolute: syphilis should be placed, like other contagious diseases, under the control of the health authorities.

The first step toward accomplishing such control would undoubtedly be found in placing it among other contagious diseases which come under the jurisdiction of the health officers; indeed, the wonder is that it has not been so placed long ago.

If syphilis were first recognised as one of the great contagious diseases, against which it is the duty of the government to protect the community, the details of that protection would follow in time, as they have in regard to other contagious diseases; as the public became aware of the dangers arising from syphilis, and the benefits accruing from its restriction, there would be no difficulty in securing proper laws relating to the subject. The suggestion, therefore, is most earnestly put forward that the time has certainly come when the dangers of syphilis, and especially the dangers to innocent persons should be fully and fairly recognised and met. It is too late in the history of science and of humanity to stigmatise the disease as "venereal," and on that account to withhold scientific protection from thousands of innocent sufferers. Among babies, nursing women, persons infected in dental and surgical operations, and in dozens of other innocent manners, syphilis can no more be described as venereal than can any other contagious disease. The time has come to place it under the control of the proper health officers, and to make it quite as *criminal to transmit syphilis wittingly*, as it is to communicate small-pox, scarlatina or diphtheria. It is believed that if only syphilis can be included on the list of contagious diseases which the health boards can control, proper legislation will follow slowly as the profession and public become more enlightened as to the real nature of syphilis and the real danger of the public from it.



## Clinical Records.

### VASOGEN IN THE TREATMENT OF SKIN DISEASE.

By DAVID WALSH, M.D.,

Hon. Physician, Western Skin Hospital, London, W.

THE value of a good excipient is so universally recognised by all dermatologists that there need be no apology for publishing the records of a few cases in which a new material of that kind has been used. Before making any trial of vasogen, with various preparations of which the following cases were treated, it was ascertained that actual absorption took place when rubbed for a long enough period into the skin. That property is specially desirable in cutaneous medication, and in the case of vasogen is attributed in part to its peculiar ability to form a stable emulsion with the secretions of the skin and of wounds, as it does with water. On the whole it may safely be said that the preparation is worthy the careful attention of practitioners who are called upon to treat diseases of the skin.

S. O., female, single, *æt.* 24, confectioner, complaining of a rash of several weeks' duration. There were scattered over arms and body a number of patches, fawn-coloured or faint pink; slightly scaly; a little irritating at times; growing rapidly from a small spot to (usually) a ringed round or oval patch the size of a shilling or a crown. Patient had a similar attack a year ago. The scalp was affected with a mild, dry seborrhoea. General health good except a little dyspepsia at times. The rash disappeared after about six weeks' treatment with vasogen, iodine, and creolin baths.

E. M., female, *æt.* 31, m., no children, complains of rash on hands of six weeks' duration; similar attack a year previously. Rheumatic fever in family. General health good. Three fingers of the left hand were in an eczematous condition, dry and desquamating, except one small patch, which was moist and excoriated, and one nail had been shed. The attack came on after washing and was diagnosed as a dermatitis, due to an irritant applied to a rheumatic subject. Under the application of a diluted vasogen iodine ointment (5ij. later increased to ʒiv. to the ʒj. of vaseline) immediate improvement took place. Some fresh crops appeared a month later, but at the end of two months the hand was cured. [The treatment of eczematous conditions by iodine certainly deserves further attention.]

E. G., female, *æt.* 41, m., five children, three miscarriages. Complaining of roughness and cracking of skin of palms for the last three or four years; hands have got well in summer, except this year. Has avoided soda in washing since the hands were attacked. At first the conditions improved under sulphur vasogen externally, and a soda and gentian mixture. After a month the patient was treated locally with mercury vasogen, and internally with a potassium iodide mixture. The hands then improved steadily, and were nearly well when patient ceased attendance at the hospital.

A. R., female, *æt.* 24, confectioner; all hair of head lost rapidly, and partially of eyebrows. Phthical family history and patient has had hip disease. The scalp was treated with a stimulant application of vasogen siccum with cantharides and ammoniated mercury. The patient volunteered the fact that the ointment disappeared after prolonged rubbing. After some weeks a growth of fine downy hair appeared over some parts of scalp, comprising about one-fifth of the total area.

E. S., male, *æt.* 52, clerk, has suffered for two years from an affection of palms. Five years ago he was treated for eczema of knees and leg. Good family and personal history. The palms showed a chronic desquamative dermatitis, extending slightly down the fingers and fading into healthy skin. Patient showed little progress under ordinary treatment, but has

improved steadily under vasogen iodine, and at the time of writing has a full prospect of recovery. [In other chronic palmar eczemas a similar treatment has proved satisfactory.]

### PSEUDO-TABES AFTER POLYNEURITIS.

By Dr. SYLLABA,  
Of Rennes.

I HAVE recently had under observation four cases of pseudo-tabes dorsalis after an attack of polyneuritis. This disease is sometimes known as "neuro-tabes peripherica" or "ataxic polyneuritis."

The first case was that of a compositor, *æt.* 62, with a gait of a gallinaceous or "stepping gait" and slightly ataxic; patellar reflex and Romberg symptom lost. On the other hand, the pupils were normal, and the sensibility of the large nervous trunks was quite intact, which justified the diagnosis of pseudo-tabes following an attack of polyneuritis, which came on with great pain in both lower extremities. The cause of the neuritis was due, I believe, to an advanced state of arterial sclerosis, which is not uncommon in the aged, and has been termed by Schlesinger, Oppenheim, &c., "polyneuritis senilis." It has, however, been objected that the vascular sclerosis could never reach such a degree as to produce pseudo-tabes.

My second case developed after an attack of typhoid fever. The patient, *æt.* 28, was a merchant, and four years ago suffered from a severe attack of typhoid, bleeding from bowel, three months' fever with frequent recurrences and great decubitus. All the limbs became paralysed, so that he had to be fed during four subsequent weeks. A year after the commencement of the fever the patient developed the gait of a gallinaceous, or "stepping gait," with paresis of the lower extremities and loss of patellar reflex. Electric treatment improved the condition, but has not cured it.

The third case was that of a diabetic female, *æt.* 40, who, during treatment for her disease, developed pseudo-tabes, followed, after the lapse of one year, by paresis of the lower extremities, distinct ataxia, and loss of patellar reflex. There is also extensive disturbance of the sensibility, with Romberg's symptom, which is not uncommon in diabetes, according to Williamson occurring in 50 per cent. of diabetics. The polyneuritis diabetica is not due to the hyperglycæmia, but rather to the toxic products of a morbid metabolism, which may resemble the acetone production, though not identical therewith.

The fourth case succeeded arsenic poisoning, which is not a common occurrence. After taking arsenic, sensibility in the extremities was affected. Along the course of nerve trunks the sensibility was greatly exalted, while the Romberg symptom was very prominent, the nails falling off and the patellar reflex disappearing. The most interesting point in this case is the "perverse dissociation," viz., that although the sense of touch was quite lost in both hands and feet sensation to pain and heat was quite intact.

## Transactions of Societies.

### BRITISH GYNÆCOLOGICAL SOCIETY.

MEETING HELD JUNE 13TH, 1901.

The President, MANSELL MOULLIN, M.A., M.B.C.P., in the Chair.

#### EXHIBITION OF SPECIMENS.

MR. W. H. NEWNHAM, M.A., M.B., physician-accoucheur Bristol General Hospital, showed a Fibro-myoma, which consisted of four distinct tumours, growing from one base, one of the four having become quite calcareous in parts. The patient, E. F., *æt.* 40, first seen in consultation with Dr. Perrott, was suffering from a large abdominal tumour which caused difficulty in micturition and defæcation. She had always had excessive hæmorrhage at the menstrual periods, but during the last three years this was accentuated and was accompanied by great pain. The uterine sound only passed three inches,

but the tumour completely blocked the pelvis. On February 21st, 1901, the abdomen was opened and the tumour removed by intra-peritoneal hysterectomy. Both ovaries were left behind, and the uterine arteries were not secured until the tumour had been removed. There was no hæmorrhage. The patient recovered without a single bad symptom, and left the Bristol General Hospital on March 18th, 1901, or twenty-five days after the operation. At the present date she is in perfect health.

Dr. MACNAUGHTON-JONES showed a specimen of Ectopic Gestation. The patient, æt. 30, had been nine years married; eight years since her last pregnancy, during which period the catamenia were quite regular up to November 24th, 1900. She had been treated on different occasions for retroversion of the uterus and prolapse. The symptoms of sudden, with periodical hæmorrhage, and violent pain, subsequently, and the formation of a large swelling behind the uterus, indicated ectopic gestation. Abdominal celiotomy was performed on April 1st, when a large adherent gestation sac of the right tube was removed. On bringing it through the enlarged abdominal incision a portion ruptured, allowing a quantity of horribly foetid and septic pus to escape. The peritoneal cavity was thoroughly cleansed out with weak formalin solution, and the edges of the wound wiped with a stronger one. Drainage by iodiform gauze was employed. From the symptoms, on the fourth day, it was found necessary to re-open the wound, when the peritoneal cavity was seen to be free of any accumulation, but the margins of the wound were infected throughout its entire extent, the slough being in the muscle and fascia. The patient died on the seventh day.

Mr. TARGETT had made a careful examination of the specimen, proving it to be one of tubal gestation, with a secondary sac between the gestation sac and the wall of the dilated Fallopian tube, in which the foetid pus had accumulated. This lay next to the bowel, with which doubtless it had formed adhesions, thus accounting for the infection. The gestation sac contained a fœtus corresponding with the stage of development at the end of the second month. The suppurating cavity represented that part of the dilated ampulla of the tube not occupied by the gestation sac.

Dr. MACNAUGHTON-JONES said that if such an accident occurred with him again he should feel inclined, having protected the bowel, to char the edges of the infected parietes with the thermo-cautery, and then make a clean section of the edges of the wound at either side before uniting it. In this case the peritoneum had clearly resisted the infection, which was limited to the parietal structures.

The PRESIDENT said that, when in an extra-uterine foetation the fœtus had become putrescent or any extravasated blood had become septic, the operation described by Dr. Macnaughton-Jones was almost invariably fatal. If the septic condition were recognised before operation, the vaginal route should be adopted, and the patient's life would then probably be saved. In the absence of evidence of sepsis, the operator naturally selected the abdominal route.

Mr. FURNEAUX JORDAN said that, no doubt, as Dr. Macnaughton-Jones had suggested, the adhesion of the sac wall to the bowel, and its becoming thin at that particular point, accounted for the infection of its contents. An interesting point, exemplified by this specimen, was that such a condition might remain quiescent for two or three months, or longer. The fœtus had evidently been discharged when the patient had the first attack of pain and hæmorrhage. Mr. Furneaux Jordan then described the following case, in which the history was very similar to that of Dr. Macnaughton-Jones' patient. A lady was twice cured in America for supposed retention of the placenta after abortion. She then gradually improved, and menstruated regularly for two years, when intense pain set in, in the abdomen. About ten days after its onset the abdomen became enormously distended, and the patient was found to have a high temperature. The swelling reached well above the umbilicus, and extended a little way into the pelvis, not, however, into Douglas's pouch. On opening the abdo-

men Mr. Furneaux Jordan found a sac embedded in adherent bowel and omentum. On separating the adhesions two pints of very foetid pus escaped. The fœtus corresponded in size to the duration of pregnancy prior to the abortion already referred to as having taken place in America. The patient, who was for some time in a very critical condition, ultimately recovered.

Dr. HAYWOOD SMITH asked if there were any indications, before operation, that suppuration was present, and further whether it might not be feasible to avoid putrescence by employing abdominal injections.

Mr. SKENE KEITH showed

FIVE SPECIMENS OF UTERINE FIBROIDS, THREE OF WHICH ILLUSTRATED IN A STRIKING MANNER THE VARIABLE RAPIDITY WITH WHICH THESE TUMOURS GREW.

The first specimen consisted of typical sub-peritoneal, intra-mural, and submucous growths, removed from a patient, æt. 28. Pain, fever, and hæmorrhage had necessitated confinement to bed during the six weeks preceding the operation. Four months prior to the removal Mr. Skene Keith had performed perineorrhaphy, and at that time there were no irregularities on the surface of the uterus, which he palpated without difficulty, and which appeared, from its size and consistency, to be subinvolved only. The second specimen, removed from a patient, æt. 34, had been discovered at the last confinement four years before the operation. The tumour which constituted the third specimen weighed eight pounds. It had been removed from a woman, æt. 28, and, although probably of only two years' duration, was far larger than the previous specimen. Interest attached to the fourth specimen because the patient had three years previously derived marked, though temporary, benefit from treatment by Apostoli's method. Failure to obtain permanent relief from electrical treatment was explained by the submucous position of the tumour. The tumour in the fifth specimen, removed from a patient, æt. 45, was of a fibro-cystic nature. The body of the uterus, which was shown, contained two polypi. The weight of the growth was 14 lbs. Commenting upon the exhibition of such specimens by an advocate of Apostoli's treatment, he said that the conditions had materially altered since he visited Paris to see Apostoli in 1887. At that time the published results in hysterectomy showed a mortality of over 30 per cent., or one death in three, though his father only lost one patient in twelve; but even with this lower mortality it was not considered justifiable to advise operation unless the patients were really very ill. The mortality to-day was less than 5 per cent.; though in some instances this figure was exceeded, e.g., at the Samaritan Hospital, where for the last two years there was a mortality of 10.6 per cent. At the same hospital the death-rate, after ovariectomy, for the same two years was 16.6 per cent., and in the year 1899, 19.6 per cent.

Dr. HODGSON, in comparing the abdominal and vaginal routes for operation, questioned the possibility of rendering the vagina permanently aseptic. It might be rendered temporarily so, but was liable to become subsequently infected from the rectum, or by discharges from the uterine cavity. He doubted the possibility of distinguishing by touch between the various internal organs, alluded to by Dr. Alexander in his paper, if adhesions existed. Referring to Dr. Alexander's statement that it was rarely necessary to employ sutures to close the vaginal wound, Dr. Hodgson said he thought that they should, at least, be employed to keep the edges of the peritoneal opening accurately together. In the majority of vaginal operations the operator was working in comparative darkness; and, subsequently, adhesions were much more likely to occur. These considerations lead him to believe that the abdominal route should be that of selection.

Adjourned discussion on Dr. Alexander's paper on  
POSTERIOR VAGINAL CÆLIOTOMY IN OPERATIONS FOR  
PELVIC DISEASES,

which was read at the previous meeting, and appeared in this journal on May 22nd.

Mr. FURNEAUX JORDAN (Birmingham) said that Dr. Alexander's paper was of peculiar interest to him, as he

had long advocated the adoption of the vaginal route in suitable cases. He did not regard the question as one of operation per vaginam versus operation per abdomen. Removal by the vagina was to be regarded as an additional method of treating disease, which, in certain cases, was devoid of many of the dangers attending removal by the abdomen. It was not possible to lay down hard and fast rules. The route adopted should be determined by such considerations as the relative sizes of the tumour, the pelvis, and the vaginal canal, the nature of the disease, and the condition of the abdominal walls. He approved of the use of the clamp to secure the pedicle of a cyst or a Fallopian tube, and had never seen harm result from its employment. He had in one case of acute suppurative peritonitis, in which there was such distention of the abdomen that breathing was seriously hampered, made an incision into Douglas' pouch without the administration of an anæsthetic. Three pints of pus escaped, but the woman, who was dying at the time, lived only a few hours afterwards. With the exception of this case, which was only technically a vaginal cœliotomy, though he had performed this operation over sixty times, not only had he no deaths, but he had never seen trouble follow. The patients were able both to get up and to resume work earlier than were those in whom an abdominal incision had been made, and did not have to wear a belt. These were considerations of importance to poor women. Lastly, the absence of an abdominal scar was an advantage should the patients subsequently become pregnant. The vagina could be rendered aseptic to the same degree and as easily as the abdominal wall, an opinion substantiated by the results obtained when the vagina was availed of for the removal of disease. Those who denied the possibility of rendering it aseptic should bring forward or quote cases in support of their contention. If those opposed on theoretical grounds to removal of disease by the vagina would give the method a trial they would be convinced of its value.

Dr. MACNAUGHTON-JONES said that the first point in selection of the route was the diagnosis. There must ever be a proportion of cases which could only be operated upon by abdominal cœliotomy, and others in which on every ground preference should be given to the vaginal route. The indications for and against one or the other had been times out of number discussed *ad nauseam*. Given a case suitable for operation by vaginal cœliotomy, whether we looked to the facility of operation or post-operative consequences, both in the risks and prevention of these, as also ready drainage when required, it certainly was the method for selection. This fact, however, in no way touched the advantages claimed for, and which were indisputably appertaining to the Trendelenburg method, in the greater control of parts, certainty in technique, and exposure of the operative field. He preferred ligatures to clamps in the vaginal operation.

Dr. ALEXANDER, in reply, said that he did not think proximity to the rectum a valid objection against vaginal cœliotomy. The field of operation was as close to the rectum in abdominal cœliotomy as in vaginal; in fact it occupied the same place. The vulsellum forceps effectually closed the os uteri, and provided against infection from that source during the operation. After the operation the vagina was packed with antiseptic gauze, which not only kept it sweet but drained away any discharge as it was formed. As to dealing with adhesions, they were as a general rule easily separated by the finger, and it was generally possible, by manipulating the speculum, to actually inspect the field of operation, so that we were really not working any more in the dark than in abdominal cœliotomy. Stitches were not necessary. The wound was closed effectually by the falling back of the uterus and the bladder, and the edges came together so accurately that there was no overlapping. Dr. Alexander was glad to hear that Mr. Jordan agreed with him as to the use of clamps instead of ligatures. The tissues to be dealt with were generally so soft that it was impossible to catch them and pull them down by forceps without running the risk of tearing them away from their attachments, whereas the clamps could be

applied without any such disturbance, and the prevention of hæmorrhage was certain. He did not agree with Dr. Macnaughton-Jones as to the ease with which a bleeding vessel could be found in these operations. The bleeding point in vaginal cœliotomy lies high up at one of the extremities of the broad ligament, and probably could not be reached and tied without opening the abdomen. It was therefore absolutely necessary that all possibility of hæmorrhage should be prevented at the time of the operation, and this was done most effectually by clamps. In vaginal cœliotomy, the possibility of hernia was completely avoided, and although the present method of performing abdominal cœliotomy guards more effectually than the older methods against its occurrence, still the possibility of hernia was always present, and in all probability took place much more frequently than surgeons admitted. He noticed that it was always the most recent method of operating that was supposed to prevent hernia. The truth really was that all methods failed, and that a considerable amount of time was required to show whether hernia would occur or not. In sloughing ectopic gestation such as the case Dr. Macnaughton-Jones had read, the vaginal route would certainly have been much safer, and although the sac could not have been removed by that route, still the dangerous contents of the sac could first have been drained with safety, and then the shrunken tumour could have been removed by the abdominal route. In fact this was the course adopted in a similar case described by Dr. Alexander in his paper.

Dr. HERBERT SNOW then read a paper on

#### SOFT ŒDEMATOUS MYOMA,

which will be found in another column.

Referring to this paper, Mr. CHAS RYALL, F.R.C.S., mentioned a case of "single soft myoma uteri," which he had removed by abdominal hysterectomy. *Case.*—D. F., surgical nurse, æt. 37, admitted into the Cancer Hospital suffering from a rapidly enlarging tumour of the abdomen. *History of present trouble.*—She had first noticed the abdominal swelling seven months ago, since when the abdomen has steadily enlarged, though there had been no pain until quite recently, and then only a slight dragging pain in the right inguinal region. The menstrual periods had become more profuse, lasting seven or eight days, and occurring every three weeks. There has been marked loss of flesh and strength, but no great anæmia. *On examination.*—A large, smooth, and solid tumour was found rising out of the pelvis and connected with the uterus. Bimanual examination showed a large mass projecting into the pouch of Douglas, and the tumour was found to have little mobility. A soft single myoma was diagnosed, and hysterectomy was recommended because of the rapid growth. *Operation, January 29th.*—The abdomen was opened in the middle line, and the uterus and tumour were drawn out of the wound with the aid of a myoma screw. After securing the broad ligaments, the uterus was amputated about the level of the os internum, the peritoneum was sewn over the cervical stump, and the abdominal wall sutured in three layers. The tumour was a soft single myoma of the sub-mucous variety, and occupied the posterior uterine wall. The uterine cavity was considerably enlarged, and the sound could be passed for six inches. The patient made an uneventful and uninterrupted recovery.

#### LARYNGOLOGICAL SOCIETY OF LONDON.

MEETING HELD JUNE 7TH, 1901.

The President, Mr. CRESSWELL BABER, F.R.C.S., in the Chair.

#### CASES AND SPECIMENS EXHIBITED.

Dr. F. DE HAVILLAND HALL showed a case of "Ulceration of the Larynx (? tuberculous)" in a man, æt. 48. There was no history of venereal disease or other previous illness. The affection commenced with loss of voice about twelve months ago, accompanied by cough and some expectoration, but no hæmoptysis.

There had been considerable loss of flesh, and there were signs of consolidation at both apices. Tubercle bacilli had been found in the sputum. He had been treated with iodide of potassium with but little, if any, improvement.

Dr. ST. CLAIR THOMSON considered the case one of tuberculous ulceration in a syphilitic subject, with which opinion Dr. de Havilland Hall concurred.

Dr. ST. CLAIR THOMSON showed a case of malignant growth of the larynx. The anterior four-fifths of the right cord was occupied by an oblong growth with an irregular mammilated surface. The anterior third of the left cord was also infiltrated. The point chiefly raised by Dr. Thomson was whether the whole of the right and the anterior third of the left cord could be removed without fear of stenosis.

Sir FELIX SEMON said that he had several times excised both vocal cords without any subsequent stenosis, and he thought the growth might be freely removed in this case.

#### THE EXTERNAL OPERATION ON THE FRONTAL SINUSES.

Dr. ST. CLAIR THOMSON also showed a case of frontal sinus suppuration fourteen months after the external operation, and

Dr. HERBERT TILLEY showed three cases demonstrating the result of the external operation. The completeness and permanence of the cure of the nasal suppuration due to frontal sinus suppuration, and the fact that the external scar was trifling and did not increase with time, were well illustrated by Dr. Thomson's case. Dr. Tilley's cases were shown to demonstrate that if the radical operation were effectively carried out, there was no reason why the recurrence of the discharge should take place with lapse of time, as had been suggested at a previous meeting. These cases had been operated on fourteen, nine, and six months ago, respectively, and there was still no trace of purulent discharge into the nostrils.

Mr. W. G. SPENCER asked what percentage of these cases was bilateral. He had noticed that most of Dr. Tilley's cases were unilateral, and he wondered whether this was due to the performance of an early radical operation on the one side preventing the empyema from becoming bilateral.

The PRESIDENT thought that the main point of interest was the exact radical operation which should be undertaken, and said the Society would be glad to hear the remarks of the exhibitors on the point. Two points had been clearly established: first, that an attempt should be made to stop the discharge by washing out the sinus from the nasal cavity; and secondly, that if radical operation were demanded, it was usually necessary to previously remove the anterior end of the middle turbinate.

Dr. THOMSON, in reply, said that in his case the anterior end of the middle turbinate was removed sixteen days before operation, by which efficient drainage had been secured. At the time of the operation the frontal sinus was found full of pus and entirely lined with degenerated polypoid mucous membrane. He had kept the wound open for eleven weeks, seeing that unsatisfactory results and even fatal cases had been put on record. Another factor in the treatment of his case was that the fronto-nasal duct had been cleared out but no drainage tube inserted.

Dr. TILLEY, in reply to Mr. Spencer, said that in twenty-three cases of frontal sinus empyema with which he had to deal, ten cases had been bilateral.

Dr. HERBERT TILLEY also showed two cases of thyrotomy for malignant disease of the vocal cords, in which the operation had been performed five and three years ago respectively. The patients were now in perfect health, and in one the voice was quite good.

Dr. FURNISS POTTER showed a case of infiltration of the left cord in a man, *æt.* 28, which was thought to be tuberculous.

Dr. MACKENZIE JOHNSTON showed a specimen of a cheesy mass found after removal in an adenoid growth. The mass was about the size of half an almond.

Dr. JOHNSTON also showed a specimen from a case of sarcoma of the tonsil with a microscopic slide. In this case an extensive external operation had been performed. By dividing the lower jaw and tying the external carotid, the whole disease had been got successfully away without marked hæmorrhage. The patient made an excellent recovery and was at present perfectly well.

Dr. DONELAN showed a sketch of an aneurysm of the aorta, in which paralysis of the left vocal cord was the only physical sign during life.

Dr. FITZGERALD POWELL showed a case of separation of the upper lateral cartilage of the nose in a male, *æt.* 25. The patient received a blow on his nose, which was followed seven months later by an abscess of the septum, which was opened and drained. From this time falling-in of the nose took place from the separation of the cartilages. He considered the case of interest as a comparison to one shown by Dr. Frederick Spicer at the previous meeting, which the latter considered to be due to the pressure of polypi.

Mr. W. G. SPENCER showed a case of chronic ulcer of the septum which, as it had lasted over a year and had shown signs of healing in parts and of extension in other parts he considered must be due to lupus or tubercle. Dr. MACKENZIE JOHNSTON, Mr. PARKER, and the PRESIDENT thought the ulceration was of a simple nature, and could see no signs of tubercle.

Mr. A. HUDSON showed an apparatus for vibratory massage which he had found beneficial in diseases of the eye and ear, and suggested that it might be useful in the pharynx and larynx for bringing about absorption of inflammatory thickening and for the stimulation of muscles in cases of paralysis.

Sir FELIX SEMON showed three cases of

#### BILATERAL ABDUCTOR PARALYSIS

in *tabes dorsalis*. In the first case the illness began three or four years ago with pains and "pins and needles" in the feet and "choking attacks" at night. Stridor at night was noticed three years ago, and for the last three months in the daytime also. On examination of the larynx, marked double abductor paralysis, almost complete, was found. There was inspiratory inward movement of the vocal cords. Tracheotomy became necessary.

In remarking on this case Sir Felix Semon said he wished to draw particular attention to the fact that since the performance of tracheotomy the inspiratory inward movement of the vocal cords had ceased. This fact he held to be important in connection with the question whether such inspiratory inward movements were due to a purely mechanical cause, *viz.*, to the rarefaction of the air below the obstruction during inspiration—a view held by the older laryngologists, and by the speaker,—or whether it represented an active inward movement of the vocal cords due to the fact that, during respiration both abductors and adductors were simultaneously innervated, and that the abductors having been paralysed, the innervation of the adductors alone prevailed. This view had been advocated by Rosenbach, Burger, and others. If it were correct, one would naturally expect the inspiratory movement to continue even after the performance of tracheotomy. The disappearance of the movement in the present case was held to point strongly in favour of the mechanical theory.

In the second case the illness began three years ago with a heavy feeling of the feet. About five months ago the patient first had choking attacks at night. The larynx showed abductor paralysis on both sides, with paresis of the internal thyro-arytenoid and the inter-arytenoid muscles. In Case 3 the illness began with gastric and rectal crises two and a-half years ago. Ten months ago the patient had choking attacks at night, and soon after noticed the change in his voice. On examination of the larynx considerable bilateral and asymmetrical abductor paralysis was found.

## France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, June 30th, 1901.

## HYPERPYREXIA.

At the June meeting of the Société de Pédiatrie M. Guignon reported a very interesting case of hyper-pyrexia occurring in an infant, the temperature running up to 109.4° F. without any appreciable cause. If anything the child's stools were too frequent and too large. After a few days the child died, and the autopsy revealed a large collection of faeces in the sigmoid flexure of the colon.

The question naturally arises, What caused the hyper-pyrexia?

Up to the time when the child's bowels commenced to act rather freely the child complained of no inconvenience or pain, and when a gradually rising temperature called for examination there was nothing found that could account for it. Even on making the autopsy the viscera were found to be quite healthy, and there was no lesion throughout the whole extent of the alimentary canal.

We are inclined to think that ptomaines formed in the sigmoid flexure and colon generally and were absorbed, producing at first their well-known toxic action of purging and finally paralysing the heat centres, and thus through hyperpyrexia producing death.

Unfortunately there was no discussion on the case, for the night it was brought forward had been fixed for the discussion of a different matter.

It is interesting to note that the general practitioner of the past dreaded any tendency to purging in children, and treated their little patients with a dose of castor oil, rhubarb, and a little solution of opium in the early stages of the disease.

His treatment was empirical, but it was empiricism based on years of observation.

## TROUBLE AHEAD IN PERSIA.

The St. Petersburg *Siedomosti*, which keeps a keen eye upon all matters in Persia, says that the Shah is very ill, and that he is not allowed to visit France this year (although his health was so greatly improved at the Contrexéville Springs during his last visit) owing to the jealousies of his vizier and his chamberlain. The Shah's previous trip to Europe was so expensive that there is no money to spare, and the Grand Vizier does not wish his master to go *incognito*, as he would then be under the influence of his enemy, the Chamberlain, and so his Majesty must suffer.

Prince Oukhtomsky's organ describes the heir to the throne, Mohammed-Ali-Mirza, as entirely uneducated, very ferocious, opposed to all reform, and a deadly enemy to all foreigners.

## Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, June 29th, 1901.

## TUBERCULOUS PERITONITIS.

In the *Zeitsch. f. Chir.*, 59, 3 and 4, Hr. J. Lauper, assistant in the Berne klinik, contributes a paper on

this subject. It consists of a report of twenty-two cases observed in Kocher's klinik. Fourteen of these were operated on, the remaining eight only having internal treatment. Sixteen of the patients were men, six women, and two children under fifteen years of age. Of the fourteen cases operated on, in most the peritonitis was of the serous form; in four it was purulent, and in three the dry adhesive form was met with. Operation mostly consisted in opening the abdomen; in three cases the tubes and ovaries were found and removed.

Of the fourteen cases operated on, ten recovered, equal to 70 per cent.; the other four died within a year, and whether tuberculous complication arose elsewhere was not known. No intestinal fissures were met with.

For the occurrence of recovery after opening the abdomen, the following factors were supposed to be responsible:—(1) Removal of the exudation, (2) improvement of the circulation and consequently resorption, (3) separation of adhesions, and (4) the removal where possible of the primary cause of the affection. Eight cases were not operated on from some cause or other, partly on account of complications in other parts. Four of these died and four recovered. In one case tapping seemed to have a favourable effect, and was recommended in all cases not suitable for further operation. Of the cases operated on and recovered seven of them had remained well for over four years.

In the *Zeitsch. f. Kl. Med.* Prof. Riegel discusses

## THE INFLUENCE OF MORPHIA ON GASTRIC SECRETION.

The experiments made were in agreement with those performed on animals, and were to the effect that morphia exercised no inhibitory influence on the gastric secretion, but that, on the contrary, its principal influence lay in exciting the secretion, even if the effect was not immediate. Only at first morphia appeared to check the secretion slightly, but the slight check was soon more than made up by a considerable increase. Whether the long continued use of morphine tended in the end to lessen the secretion, the writer's own experience did not allow him to decide. In his experiments on dogs, even when continued for several days, he never observed any diminution of the secretion. At the most the intensity of the stimulating effect in that direction was not so marked. The investigations make it clear that to give morphia in cases of ulcer of the stomach in the expectation that the acidity of the stomach will be diminished by it is a mistake. On the contrary, it appears desirable to bring into view and put into use the drugs that are known to have an inhibitory effect on the secretion. Whilst atropine and belladonna arrest the secretion in a marked manner, morphia increases it. Morphia may therefore be given in affections of the stomach only in cases where hyper-secretion will do no harm. When, however, excessive secretion is likely to be harmful, belladonna preparations are to be preferred, as in addition to the pain-relieving properties they also assist in checking secretion.

At the Congress for Surgery, Hr. J. Wolff, Berlin, read a paper on

## ARTHRALYSIS AND RESECTION OF THE ELBOW-JOINT.

In consequence of the unsatisfactory results of resection of the joint, the speaker had, in 1895, proposed arthrolysis for bony and firm fibrous ankylosis. He had performed the operation in nine cases. It consisted in cutting through or chiselling off, or in the removal

otherwise of all bony or fibrous structures that prevented free movement of the joint. In the case of an actress operated on in July of last year healing per primam was complete in eleven days. The passive movements then begun were, however, so painful, that the patient in the course of a few weeks declined to persevere. In September, therefore, a plaster dressing was applied, which was left flexible near the joint, and the arm was gradually brought to a condition of the utmost possible flexion and extension. From now active and passive movements were practicable. At present any difficulty or awkwardness of movement was scarcely noticeable, and the patient was able to follow her calling. When the disease in the joint was tuberculous, however, the ends of the joints so far as they were diseased had to be resected, and now the question arose whether the resection was to be typical or partial. Some operators preferred total resection in adults, but in children arthrotomy, so as to avoid arrest of growth. In a patient, *æt.* 31, typical resection was performed twenty-eight years ago, and when the arm was hanging loosely but little shortening appeared. Both humeri were of the same length. Ollier had observed an increased growth of the humerus after resection. The ulna also was highly developed. The case showed that even for children total resection might have its advantages over arthrotomy. The functions of the arm were good, flexion and extension were performed over a normal area and with normal power, and the patient was able for all her work.

In a case mentioned by v. Eiselsberg of a girl, *æt.* 17, with double ankylosis of the elbows, a good result was obtained in the left elbow, but bony ankylosis still continued in the right.

## Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, June 29th, 1901.

### SUICIDAL EFFORTS.

At the meeting of the Prague Medical Association many interesting and important subjects were discussed and cases exhibited. Among the latter was a shoemaker, *æt.* 46, who had mutilated himself with a trimming knife 12 cm. long = 4.7 inches. There was one long cut across the mamma, a stab in the seventh left intercostal space passing through pleura and diaphragm causing pneumothorax; another cut 1.6 centimetres below ribs into the stomach at the fundus, the contents of stomach passing into peritoneum when admitted; and, lastly, a wide opening across the abdomen through which protruded four metres of intestine, omentum, and mesentery, covered beyond recognition with straw, pitch, dirt, &c.

The stomach was first stitched, the omentum resected, the bowel replaced, the whole abdomen washed out, and proper drainage provided for by gauze strips.

On the third day post-operation symptoms appeared in the form of circumscribed peritonitis. The abdomen was again opened and an abscess discharged; the abdomen was allowed to remain open for twenty days, when granulation became general. Six weeks later a

plastic operation was performed that healed in fourteen days.

### RECOVERY FROM INTUSSUSCEPTION.

Jedlicka demonstrated a case where intussusception assumed a peculiar form of recovery. On many occasions the patient had suffered from fits of constipation and obstruction of the bowel. In one of these attacks half a metre of the bowel came away, which gave relief. Four years later an abscess formed in the abdomen, which was opened, but owing to the subsequent stenosis laparotomy was performed, when the bowel was found to be invaginated. This had been perforated in a peculiar manner through the mesentery and not through the intussuscepted bowel as might be expected. One of the convolutions was greatly dilated and was resected. Inside the part removed was found a stercoral abscess.

### RARE FORM OF STRICTURE.

Jedlicka brought forward another female on whom he had operated for volvulus with supposed strangulation.

On the second occasion there was strangulation, with an adherent tumour on the appendix, which extended as a peritoneal band to the sigmoid flexure. In the third operation, which was within three weeks after the second on account of obstruction, a recent adhesive peritonitis had occurred. Recovery took place after jejunocolotomy was performed.

### CARDIAC TUBERCULOSIS.

Hlava showed a pathological preparation taken from a young man, *æt.* 35. The myocardium of the right auricle was greatly enlarged, while the cardia was filled with a mass of tuberculous nodules, with caseous masses in the walls and pericardium, while the lymphatic glands were greatly enlarged.

## The Operating Theatres.

### ST. THOMAS'S HOSPITAL.

**CHOLEDOCHOTOMY.**—Mr. BATTLE operated on a woman, *æt.* 35, who was suffering from painful attacks in the region of the gall-bladder. She had been under his care at the hospital two years before for a movable right kidney, and the operation for this condition had been very successful. It was principally undertaken for pain, and as she had obtained relief from that pain, she came to see if something could not be done for her present illness. For a month or two at intervals she had had severe attacks of pain, commencing in the liver region, so intense that she had been doubled up with them and vomited, whilst on one or two occasions she thought that there had been some "yellowness of the eyes" afterwards. Examination of the hepatic region showed nothing abnormal. She was kept in the hospital under observation for a fortnight, during which time she was permitted to get up and walk about, but no pain was complained of. At the end of this time she was so anxious to have something done that it was decided to explore, on the possibility of there being a gall-stone present to account for her symptoms. At the operation an incision was carried through the rectus muscle over the position of the gall-bladder, and this last was examined: it was small, about the size of the end of the thumb, and contained some inspissated bile near its fundus, but no definite calculus. Four inches from the surface, however,

a small stone could be felt, blocking the cystic duct, and it seemed probable that this was the cause of her symptoms, the gall-bladder and duct behind it being abnormally thickened. The lower aspect of the gall-bladder and duct was attached to the large intestine and omentum by a fold of peritoneum, possibly the result of some old inflammatory attack, and the stone could be felt with the finger on either side of this. The resident assistant-surgeon, Mr. Corner, held the stone between two forefingers and pressed it forwards and to the right so that it came within reasonable distance and could be removed. An incision was made over this, and it escaped through the opening thus made, a small quantity of bile which followed it being received on the gauze with which the area of operation was packed. The duct was steadied in the same position by Mr. Corner until it had been sutured, Lembert's sutures being inserted. The wall of the cystic duct was very hard, as well as thickened. Before the stone was cut down upon an attempt was made to move it towards the gall-bladder, but it could not be shifted. The calculus was about the size of a horse bean and rounded in shape; it presented no facets. The wound was closed fully, no drainage being employed. Mr. Battle remarked that it was evident this stone was the only one, and as its impaction in the cystic duct was quite capable of causing symptoms, it was fair to presume that the operation would fully effect its object. The attacks of which the patient complained were typical of gall-stone colic, but the position of the stone could not be exactly ascertained because the question as to jaundice was doubtfully answered. The cessation of the pain whilst in the hospital was, he thought, probably the result of the rest and regular dieting, therefore it was possible to make definite observation whilst she was waiting.

GREAT NORTHERN HOSPITAL.

SARCOMA OF OS CALCIS (*continuation of case on p. 612, June 5th, 1901.*)—Mr. PEYTON BEALE operated on the same man from whom he had previously removed a myeloid sarcoma occupying the whole of the interior of the os calcis. At the previous operation he was unable to do more than scoop out the growth. The latter recurred within three weeks, and having regard to the fact that it was limited entirely to, and had replaced the cancellous tissue in, the os calcis, and that it was a myeloid sarcoma, and therefore not likely to exceed its present limits, it was thought desirable to remove only the entire os calcis. A vertical incision was made over the heel extending upwards about three inches, and for the same distance along the sole; the attachment of the tendo-Achillis was divided and the periosteum with attached ligaments separated as far as possible from the bone; the posterior half of the os calcis was then removed and the calcaneo-astragaloid ligaments being next severed, the upper articular surface together with the cartilage, which was quite normal, was taken away; then the anterior surface articulating with the cuboid was separated from the latter bone by dividing and stripping off the calcaneo-cuboid ligaments. Thus the whole of the os calcis was removed. The cavity was then well washed out, the ragged ends of the ligaments were cut off, and the tendo-Achillis was sutured to the plantar fascia by means of strong catgut. The wound

was finally closed with the exception of about one inch below, and through this the large cavity was stuffed with cyanide gauze. Mr. Beale said that this operation appeared to him to be adequate, because the growth had not extended through the compact bone of the os calcis at any point, moreover the cartilaginous articular surfaces were perfectly normal. It had been said that in a case of myeloid sarcoma it was only necessary to remove the growth itself, that is the actual cancellous bone, and, in the case of a long bone, the contents of the medullary cavity, but Mr. Beale had seen many cases in which proceedings of this kind had been carried out even with the subsequent application of pure carbolic or strong chloride of zinc solution, and yet the growth had recurred; he believed, therefore, the right course to adopt in cases of myeloid sarcoma was to remove the whole of the bone in which the growth was in contact, after having carefully stripped off the periosteum, by this means further recurrence was always avoided; moreover it ensured the formation of more or less new bone to take the place of that which had been removed.

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"SALUS POPULI SUPREMA LEX."

WEDNESDAY, JULY 3, 1901.

STATISTICAL FALLACIES IN REGARD TO LUNACY.

The statistics of insanity, though at first sight somewhat arid reading, are, in reality, replete with interest. From them can be extracted without much trouble a number of conclusions which throw an interesting if often fallacious light on the causation and incidence of mental disorder. Statistics are notoriously susceptible to skilled manipulation, and are even more apt to mislead when made use of by the unwary or hasty. Let us consider, for instance, the influence of celibacy as a cause, or shall we say, as a predisposing factor in the causation, of insanity. We find on looking through the Bethlem Hospital returns for last year that out of a grand total of 226 persons of both sexes suffering from some form of mental disease, 130 were single and only 83 married. These figures, taken alone, would

appear to justify the assumption that celibates are more prone to mental disturbance than the married, but, as we shall show, the difference in the incidence is more apparent than real. Taking the total number of admissions we find that they comprised 142 females and 84 males. Of these, there were ninety-four single women and only thirty-six single men, whereas, among the married, the proportions were forty-three males and only forty females. Of the patients who remained under treatment thirty-four married men almost balanced thirty-one married women. One obvious conclusion from these returns is that celibacy in the female is a more potent factor in the determination of insanity than it is among males. But is the comparison a just one? Celibacy in the female, we may take it, really implies approximate chastity, whereas in men we doubt if that can safely be advanced. The male celibate probably indulges his sexual appetite less frequently than his married brother, and presumably only goes astray at intervals, in deference to physiological stimulation. For the purpose of our argument we will assume that we are dealing only with persons who are predisposed by heredity or defective general health to some form of mental breakdown, and such subjects are, from this point of view, better off single than married, because in the latter state there is always the possibility of excessive sexual indulgence, plus the added sense of responsibility associated with the maintenance of a family. On the other hand, there are many reasons why the single state should weigh more heavily upon the unmarried female than upon the bachelor. The absence of physical and mental excitement, within healthy limits, in the life of the old maid, her naturally emotional temperament, exasperated by greater amenability to religious and other sources of psychical disturbance, render those already predisposed thereto exceptionally prone to disturbance of mental equilibrium. The influence of religious belief in respect of the incidence of insanity is another point which is of interest, though the statistics are subject to so many sources of fallacy as to be valueless from a scientific point of view; moreover, whatever the conclusion one may draw from the figures, it is always open to the critic to object that the religious factor was the result, and not in any sense the cause, of the breakdown. Of the 226 patients already referred to, 155 were registered as members of the Church of England as against thirteen Baptists and Roman Catholics respectively. We need not insist upon the inconclusiveness of any deduction establishing a special proneness to insanity among the members of a particular church. Nor are the returns of the "cured" more trustworthy from a statistical point of view. Of the 155 members of the Church of England only sixty-two were discharged during the year as "cured," and of eight Wesleyans none recovered their mental equilibrium. There do not seem to have been any agnostics or freethinkers, unless we accept the entry of *nil* in two instances as evidence of an absence of religious belief.

#### SYPHILIS AND GENERAL PARALYSIS.

THE etiology of general paralysis remains obscure in spite of the great advances that have characterised recent scientific knowledge of diseases of the nervous system. The malady has been recognised only within the limits of the last hundred years, and so far as can be gathered from the experience of experts it has of late increased rapidly in incidence. Possibly, however, that conclusion may be to some extent attributable to improved diagnosis, but after making allowance for a margin of error in that direction, there is no doubt that a greater proportion of patients suffering from general paralysis are now admitted into lunatic asylums, and that the tendency has been for the disease to develop at an earlier age-period, so as even to include childhood. From whatever point of view we regard the condition, its progressive nature in spite of treatment renders its study one of the most important within the range of modern medicine. For that matter general paralysis may be ranked with cancer and mycosis fungoides as members of the happily diminishing group of the incurable and deadly ills that affect mankind. We know that it is definitely connected with certain predisposing conditions, such as a neurotic family history, injuries to the head, dissipation, mental worry, alcoholism, sexual indulgence, and other exhausting influences, but above all, syphilis. The conviction of the importance of syphilis as a causative factor in general paralysis has grown stronger and stronger, although it must be admitted that there are still missing links in the chain of complete proof. Statistics on the subject must necessarily be received with caution, for as every medical man knows, it is often extremely difficult to get a history of syphilis, direct or indirect, in many undoubtedly syphilitic manifestations. However, it may be broadly stated that the brunt of general paralysis falls upon men rather than women, upon soldiers rather than upon priests and women of the better classes and upon the population of cities rather than of the country. In other words, the malady is found most prevalent where there is the greatest amount of syphilis. The method of the action of the syphilitic taint upon the brain is unknown, although it is possibly or probably to a great extent due to vascular affections leading to chronic inflammation and disturbance of nutrition. A similar want of precise knowledge must be pleaded with regard to locomotor ataxy, in which syphilis is now generally regarded as a common if not exclusive cause. In both diseases of the nervous system there must be some localising conditions, inasmuch as many persons suffer from syphilis whereas comparatively few develop either general paralysis or locomotor ataxy. In this way we are once again faced with the wisdom of the homely proverb which teaches us that prevention is better than cure. Do away with syphilis and you do away with the two disastrous and incurable nerve maladies in question. So far as syphilis is concerned a good deal of advance has been



made in the scientific treatment of the disease, but a great deal remains to be done by way of social reform. The Contagious Diseases Act was undoubtedly a step in the right direction. The scientific sanitarian may confidently look forward to the time when syphilis will not be sown broadcast among our population in obedience to the prudery and prejudices of a set of worthy but misguided sentimentalists.

#### ABDOMINAL PAIN IN TYPHOID FEVER.

THE significance of pain in typhoid is known to all clinicians. But the difficulty of defining the thing signified by the pain has been so appreciated by writers that practically no attempt has been made by writers on typhoid fever to attempt a differentiation of its many varieties and meanings. Louis' "*Recherches sur la maladie connue sous le nom de gastro-enterite*," found it difficult to distinguish between pain in typhoid that told of impending death and simple flatus. Jenner was not more successful, and even the classic work of Murchison and the great monograph of Liebermeister make no attempt to guide the student in the interpretation of this frequent symptom of this very common disease. Within the past few weeks it has been seriously proposed to open the abdomen, and if necessary the intestines, and seek the cause. Indeed, as a writer has proposed, in cases of pronounced meteorism an incision into the head of the colon and washing it out would be a perfectly justifiable operation. Tympanites cannot, however, account for more than a small percentage of cases in which pain is a marked symptom, and even with the aid of the surgeon, the cause will remain unknown in many cases. This is in part, at all events, due to the fact that the alimentary canal is so richly supplied by the sympathetic nervous system, of the physiology of which there is still much to be learned. The whole question has been very ably dealt with by Dr. Thomas McCrae (*New York Med. Jour.*) who urges that "It is not necessary to establish the importance of an accurate knowledge of this system." As the author says, the question of the cause of pain may arise quite suddenly, and may be associated with other symptoms of a deceptive character, which so mask the symptom of pain that a perforation may be undetected and a life lost that prompt surgical interference might have saved. From the record of some five hundred cases of typhoid in the Johns Hopkins Hospital, he found that pain occurred during the course of the attack in 32 per cent. of the cases; of these the pain was due in some cases to conditions apart from any special lesion of the disease: hysteria, lung conditions, bladder, abortion, labour, and menstruation. In another group of cases the pain was due to conditions of the gastro-intestinal tract apart from complications: vomiting, constipation, diarrhoea. Besides these the symptoms were found in abdominal conditions apart from specific bowel lesions: appendicitis,

peritonitis, cholecystitis, liver abscess, painful spleen, phlebitis. The specific intestinal complications associated with pain were hæmorrhage and perforation. And in other cases no discoverable cause was found. The physician is fortunate when hæmorrhage and perforation give rise to pain, and when his patient possesses sufficient consciousness to tell of its presence. Of thirteen cases of perforation the author found the lesion to be attended with a definite sudden onset of pain in two of them; but in three cases the pain was complained of some days before the perforation. Considering the gravity of the symptom all nurses should be instructed to immediately summon the medical attendant in all cases of abdominal pain. And we think that in serious cases of typhoid opiate, as likely to mask pain, are to be avoided.

#### Notes on Current Topics.

##### The Reorganisation of the Army Medical Service.

A "COMMITTEE of experts" has been nominated for the purpose of considering a scheme which Mr. Brodrick has drawn up for the future organisation of the Army Medical Service. This committee comprises the names of Mr. Howard H. Tooth, M.D., F.R.C.P., St. Bartholomew's Hospital; Mr. George H. Makins, F.R.C.S., St. Thomas's Hospital; Mr. Alfred D. Fripp, C.B., F.R.C.S., Guy's Hospital; Sir F. Treves, K.C.V.O., C.B., F.R.C.S., London Hospital; Mr. Alexander Ogston, M.D., Scotland; Lieutenant-Colonel Keogh, M.D., C.B., R.A.M.C., Ireland; Mr. E. C. Perry, M.D., F.R.C.P., Senate of London University; Surgeon-General Hooper, C.S.I., President of the Medical Board, India Office; and two officers who will be named by the Commander-in-Chief to represent the Army. The secretary will be Major H. E. R. James, R.A.M.C., and the chair will be taken by Mr. Brodrick himself. These names convey an assurance that the purely medical aspect of the service will receive due attention, though until we are in possession of the actual terms and scope of the reference it is impossible to gauge the precise significance of this important step. Some objection has been taken to the inclusion of Sir Frederick Treves, but we hold, on the contrary, that his experience will be of the greatest value, for he is as alive as anyone to the requirements of the service. It is doubtful whether the committee will be enabled to report before the end of the present session of Parliament, but, as Mr. Brodrick aptly observed, it is much more important that they should come to a correct conclusion than that they should be hurried in the performance of the duty assigned to them. On the other hand, the subject is one which has been exhaustively discussed for many years past, and the general lines on which reform will have to be carried out are pretty well agreed upon—a higher status, more liberal remuneration, and more considerate treatment at the hands of those in power. It need certainly not take long for the committee to formulate

its conclusions, but it may take Mr. Brodrick some time to bring these conclusions to a practical issue. We are justified in hoping that this great question will now be dealt with on a statesmanlike basis, and that the future Army Medical Service will be placed on a footing worthy alike of its members and of the interests confided to their charge.

#### The Treatment of Paralysis Agitans.

IN a former number we noted an additional method of diagnosing the onset of paralysis agitans, and now it is of interest to find a contribution on the symptoms and treatment of this disease by Dr. R. L. Williamson in a recent copy of the *Manchester Medical Chronicle*. Recognising that in the light of our present knowledge there is no treatment which can cure or even permanently arrest the progress of the disease, he has devoted a considerable portion of his article to a consideration of certain measures he has tried for the relief of the more troublesome symptoms. He strongly recommends that a patient should remain in the open air as much as possible, and has found that driving in an open carriage, in some cases, produces a temporary cessation of the tremor. He has tried a large number of drugs, but has found all of them practically useless with the exception of hyoscine, hydrobromate, duboisine sulphate, and hyoscyamine which he believes are of decided value. In using the first of these drugs he suggests that the initial dose should not exceed  $\frac{1}{150}$  gr. dissolved in 3ij of chloroform water. The quantity may be increased gradually up to  $\frac{1}{100}$  gr., and in some cases, when no toxic symptoms have appeared, he has given as much as  $\frac{1}{75}$  gr. or  $\frac{1}{5}$  gr. by the mouth. Dr. Williamson always uses Merck's hyoscine hydrobromate, obtained directly from Darmstadt. If hyoscine fails to relieve the tremor he suggests a trial of duboisine sulphate ( $\frac{1}{4}$  gr. by the mouth) or by hyoxyamine sulphate ( $\frac{1}{8}$  gr.), but as a rule these are not so efficacious as hyoscine hydrobromate.

#### Dysbasia Intermittens Angiosclerotica.

THESE are not wanting in literature instances of persons, generally past middle life, who complain of being unable to walk more than a short distance by reason of what they describe as "cramp in the legs." That remarkable clinical observer, Charcot, thought that the condition was practically one of sclerosis of the arteries of the lower extremities, and the condition appears to be associated with vascular spasm. The usual history in these cases is that after a short period of repose the sufferer is able to resume his promenade. Putnam (*Boston Medical and Surgical Journal*, February 21st, 1901) has just published the details of an extremely interesting example of this affection, called by some intermittent claudication, and sometimes referred to as intermittent lameness. The name which Putnam applies to this symptom-complex, "dysbasia intermittens angiosclerotica," though somewhat unwieldy for general use, certainly indicates very

accurately the peculiar difficulty experienced in walking, the intermittent character of the attack, and the pathological relation of the disorder. In this curious malady it has been found that the therapeutic use of electricity and baths has not been followed by any beneficial effect, and in the case quoted it is worthy of note that upon the patient, of his own initiative, taking to kneading his calves every night and morning marked improvement followed.

#### Quinine Idiosyncrasy.

IDIOSYNCRASIES have long been known and recognised. Montaigne refers to them, as do Aaiatus, Lusitanus, and Spigelius, and many other authors, but they one and all looked on them as curiosities of medical experience until M. Lorry published his "Tractatus de Morbis Cutanée" in 1777. The great importance of recognising rashes due to idiosyncrasies came in time to be recognised, and under the title "Antipathies" Milligan and other writers collected numerous examples. But until Prince A. Morrow's great monograph, "Drug Eruptions," few medical men had any idea that drug rashes so closely simulated the exanthemata. Among the more generally used drugs Dr. Morrow gives a formidable list of the eruptions that follow from the use of quinine, from the well-known pamphlet of Jean Baptiste Chevallier (1835) up to 1877. He has shown that in the majority of cases the rashes assumed a scarlatinoid, or, as more modern writers might say, "a fourth exanthem" form, "followed by desquamation of a branny or lamellar character," and of course liable to be mistaken for scarlatina, particularly as the tonsils are not infrequently inflamed, and the temperature rises to 102° F., and in some cases was as high as 104° F. or even 105° F. Of recent cases the most interesting are those given by Dr. H. A. Hare (*Therapeutic Gazette*):—"A man fifty-three years of age, was ordered a pill containing about one-sixtieth of a grain of arsenious acid and two grains of quinine three times a day as a tonic during convalescence from a severe illness. Within twelve hours of the administration of the first pill he developed an intense erythematous rash all over his body, with intense itching and puffiness of the skin about the face. At the end of five days with the subsidence of the acute injection of the skin, marked desquamation took place over all portions of the body with the same freedom as is frequently seen in severe scarlet fever, and six weeks afterwards the skin on the palms of his hands and the soles of his feet was still actively desquamating. No sooner had the symptoms appeared than the patient asked if he were receiving quinine, and on being told that he was getting the drug, he immediately recognised the cause of his difficulty, stating that he always had a similar affection when this drug was administered, even when it was given in remarkably small quantities." For this patient's daughter, a woman of twenty years of age, Dr. Hare prescribed a pill of iron, arsenic, and quinine, and she, too, developed "a general rose

rash all over her body," which was followed by an active desquamation of the palms of the hands and soles of the feet. Where a quinine idiosyncrasy exists even the topical application of the alkaloid will produce an eruption. Delieux de Savignac reports a case in which the application of a pomade containing quinine produced intense pruritus and an eruption of lichen. As quinine has now practically become a domestic remedy, it is well in all suspicious cases to inquire if the patient with an ill-defined rash has been taking the drug.

#### Sponges in Abdominal Wounds.

In the case of a surgeon who was sued for malpractice, because the head-nurse of a hospital who was personally in charge of the sponges at an abdominal operation forgot that one had not been removed before the wound was closed, a verdict was given acquitting the surgeon of blame, but the matter has aroused further interest because it is now sought to prove that the hospital employing the nurse is responsible. He would be a rash man who counted upon the Law Courts acquitting a surgeon who was aware that a nurse assisting at an operation was in any way careless, but it certainly would be manifestly unfair to hold an operator responsible for the acts of a duly qualified nurse on the ground that she was technically the surgeon's agent. A new terror will be added to the life of a hospital surgeon if he is to be held accountable for whatever may happen to his patients in consequence of the shortcomings of the nurses on whom he must depend in his work.

#### Cabmen and Street Accidents.

A FEW days ago a well-known actress found lying in the street a child who had been crushed by a grating. She hailed a cabman, whose first question was not unnaturally who was to pay him his fare for taking the child to a hospital. The point being settled, the little sufferer was removed to the desired haven of safety after a delay of four or five minutes due to the discussion about payment. In a subsequent interview published by a London newspaper the lady in question raised the point as to the duties of cabmen in case of accidents. Clearly enough there is no law that can compel the driver of a cab to carry persons gratuitously, no matter what their physical extremity may be. That fact occasionally leads to exhibitions of callousness in the streets of London that would be worthy of Chinese cruelty in its most cynical form. A man may be picked up writhing and half dead after being run over by an omnibus or other vehicle, and the first question asked him by the bystanders is probably whether he has any money to pay for a cab. The police are empowered to carry off in a cab any person who is ill or has met with an accident in the streets. The hospitals certainly do not pay for cabs that bring patients to their doors. From the point of view of the cabman, there is much to be said against his being made the vehicle of compulsory charity. As

a rule he has hard work to make both ends meet, and his employer would make no allowance for time spent in carrying disabled persons from one place to another. Again, the cabman is answerable for any damage done to his cab, and he would be liable to any amount of mischief from persons picked up in the street. Some years ago when a woman jumped from the suspension bridge at Clifton and fell in the mud a cabman passing by refused to take her to the hospital because of the damage the mud with which the unfortunate woman was covered would do to his cushions. The best plan would be for the hospitals to pay fares in all clearly suitable cases. The public would certainly not grudge the money spent for so necessary a purpose.

#### The Leper Mission.

It would be not easy to imagine any mission framed upon a more absolutely ideal Christian basis than that which has been organised to the lepers of India. It is to be feared that the extent to which that loathsome disease prevails in our great Eastern dependency is not generally recognised by the dominant nation here at home. In 1898 the Indian Government passed an Act providing for the segregation of mendicant lepers, and forbidding lepers to handle food or to carry on trades dangerous to the community. It has recently been resolved to enforce that measure in Bengal, presumably as an experiment to test the feeling of the native population. In Nepal it has been stated that a person found to be suffering from leprosy is sometimes buried alive by the Brahmins, and in Sumatra at times the relatives of a leper burn him to death in his house, pushing him back into the flames should he attempt to escape. The mission does not confine its energies to India, but does good work also in China and Japan. It has no less than sixteen centres of work, and supports twenty-seven asylums or settlements, and in this way does its best to care for about a million lepers said to exist in the countries above mentioned. In India the housing and food of an adult leper can be provided at the modest rate of £5 a year. As a preventible disease leprosy can be banished from the face of the earth by the strenuous application of modern preventive science. Unhappily, it seems likely to linger for generations in India, which under present conditions is the favoured home of cholera, enteric fever, plague, and other specific scourges of mankind.

#### Beauty Making.

THE desire for beauty on the part of the female is one of the most deeply-rooted characteristics of the human race. That it is answerable for a vast amount of folly and frippery goes without saying. Unfortunately the door is thrown open thereby for the host of harpies who batten upon the foibles and weaknesses of mankind. In this way abound myriad specialists in baldness, in the destruction of superfluous hair, in the removal of fat, wrinkles, freckles, moles and blemishes of all and sundry

kinds. To a certain extent the treatment of many facial defects, such as an everted eyelid or a disfiguring birthmark or scar falls within the limits of legitimate surgery. But the value of such procedures is ascertainable upon a moderate and well-defined basis. The claims of the quack, on the other hand, are boundless, and would be ridiculous to any but a woman whose judgment was swamped by an overwhelming desire for sexual attractiveness. A New York lady, so it is announced in the *Daily Express*, has brought an action for £12,000 damages against some operators who undertook to restore the youthful contour of her face, to make a dimple in her chin, to raise the drooping eyelids, to draw back the skin and make it smooth on the forehead, to redden her lips, and straighten and point her nose. It will not surprise any practical surgeon to learn that a series of operations to fulfil that extremely large order resulted in making the lady plainer than ever, with the addition of numerous scars. It is to be hoped that the publication of this distressing case will stay, for a time, at any rate, the hand of the professional beauty maker.

#### Instruction in the Use of Anæsthetics.

THERE are rumours that instruction in the administration of anæsthetics is soon to be included in the curriculum, and one's feeling must be that of mild surprise that this important detail should hitherto have escaped adequate treatment. The difficulty in the way of ascertaining the practical knowledge of the candidate in this direction does not account for the fact that no questions are usually set on the subject. We do not hesitate to affirm that a certain proportion of the deaths from anæsthetic narcosis which it is our melancholy duty to chronicle from week to week are more or less attributable to the fact that practitioners have, for the most part, to learn to give chloroform as best they can in actual practice. The basis of such teaching will of course be an intimate knowledge of the physiological effects of anæsthetics in large and small doses, but the various methods of administration must also be taught, and every candidate should be required to show that he is familiar with the use of some kind of regulating apparatus. The reluctance of most practitioners to employ any apparatus is, we believe, largely the result of their ignorance of its use, yet in this direction, in all probability, lies the secret of safety in anæsthesia. No apparatus yet devised can avert risk in the hands of the careless and inexperienced, just as no measure, however accurately graduated, is of itself an obstacle to a poisonous dose of a drug being dispensed. On the other hand, death under chloroform when such an apparatus is resorted to, is the rarest of occurrences and almost without exception those which it falls to our lot to record, have followed the old-fashioned practice of pouring the drug on to a towel or mask. Apart from the risk of inducing fatal narcosis, imperfect anæsthesia militates against the success of

the surgeon, who is seriously handicapped when, in addition to the problems requiring his immediate attention, he is hampered by difficulties of this kind. No doubt when the subject comes up for consideration before the General Medical Council a sufficiently comprehensive schedule will be devised, and a notable lapsus in medical training will thus be remedied.

#### Trichinosis.

A CERTAIN Professor Joseph Leidy, about fifty years ago, in cutting a slice of cold ham to make a sandwich, noticed a number of little specks, and, as the *Journal of the American Medical Association* puts it, the fact that Leidy's scientific curiosity got the better of his appetite gave rise to a special occupation which now gives employment to over 50,000 persons, which resulted in the prohibition of American pork into Germany for a period of nine years, entailed on American exporters a financial loss estimated at millions of dollars, saved hundreds of human beings from disease and death, inaugurated an elaborate system of public hygiene, and gave a mighty impulse to the study of the etiology of disease. It is a curious fact that during the exclusion of American pork from Germany there was an annual average in that country of 454 cases of trichinosis, but since the re-admission of American pork in 1892 the annual average has only been 149. In the opinion of so great an authority as C. W. Stiles, the total prohibition of German pork in Germany and the compulsory use of American pork would probably do more to eradicate trichinosis than does their elaborate system of microscopic examination. In Germany there is a widespread custom of eating raw pork, and a feeling of false security is fostered by reason of the Government employing an enormous number of trained observers to microscopically inspect the commodity. It would be wiser to educate the consumers so that they would of themselves abstain from partaking of pork that was not thoroughly cooked or cured. Outbreaks of the disease in this country have brought the subject of trichinosis into prominence, and the recent address of C. W. Stiles before the Philadelphia Pathological Society, published in Volume IV. of their "Proceedings," should receive the very closest attention of all who are interested in the public welfare.

#### Gold Blindness.

HYPERMETROPIC members of the dental profession who are also astigmatic are in some cases liable to lose the power of distinguishing gold-filling from the tooth on which they are working. This form of retinal asthenopia appears to be due to abnormally rapid exhaustion of the visual power, and the trouble is noticed to occur when the eyes have been kept fixed upon a small gold stopping for a length of time, the warm yellow colour of the metal tending to exaggerate the preexisting defect. In addition to inability to distinguish the filling from the tooth dentists who present this defect cannot recognise

clearly the contour of the hole they are stopping. In the *Canadian Practitioner* for June it is pointed out that age does not predispose to this affection nor does youth exclude it. The primary cause of this particular form of blindness indeed is probably the excess of yellow rays from the gold metal. After a few days' rest the sufferer is enabled to resume work as before, but recurrence frequently takes place, and the intervals during which work can be carried on become shorter and shorter. The treatment suggested by Mr. L. Webster Fox is, first to correct any error of refraction, to examine carefully into the general health of the patient, and to advise that nothing tight be worn round the neck. The last direction is necessary in consequence of so much dental work having to be done with the head bent. The intense white light which accompanies the fusing of gold plates contains an excess of yellow rays, and it is suggested that this constitutes the causative factor in the disorder.

#### A Difference of Opinion.

THE best way, when there is a difference of opinion between practitioners in regard to a case, is for them to have a fresh examination when both are present. It can be but seldom under such circumstances that they will fail to arrive at a common accord. Unfortunately, this course is not always practicable, nor is it usually resorted to even when it is. A regrettable difference of opinion became manifest at the Westminster Police Court last week in reference to the mental condition of a refractory young woman. The medical officer of the prison and the divisional surgeon both arrived at the conclusion that she was insane, and she was sent to the workhouse infirmary. There the medical officer decided that she was sane and discharged her, thus placing the magistrate in a somewhat difficult position. True, this difference of opinion testifies to the conscientiousness with which the various medical officers fulfil their responsible functions, but it interposes grave difficulties in the administration of the law, and means ought to be found of settling such questions without throwing the onus of deciding the sanity or otherwise of the accused on the magistrate, who is hardly fitted to decide which view is the correct one.

#### Lady Medical Officers.

THE question of appointing a woman to the post of resident medical officer at the infirmary gave rise to an animated discussion last week by the Birkenhead Guardians. The Board had on a previous occasion declared by a large majority that they preferred a resident medical officer of the male sex, and had advertised *de novo* for one, but, as they only offer £130 per annum, not a single application was received in response thereto. Thereupon the Board resolved to appoint Dr. Eva McCall, at present Assistant Medical Officer at the Salford Union Infirmary, at a salary of £120 for a trial period of twelve months. We hope, without being over sanguine, that this lady will decline the

reduced scale of remuneration, because nothing is more calculated to maintain the hostility of the profession to female competitors than the willingness with which they, or some of them, play into the hands of parsimonious boards. We note that the lady's male colleague will be expected to take all the "objectionable" cases off her hands, but no mention is made of any arrangement which will rid this gentleman of cases which he himself may find objectionable. If ladies elect to compete in the medical field it must be in accordance with the principle of a "fair field and no favour."

#### Did Napoleon Die of Cancer?

THE belief is very general that the cause of death of the great Napoleon was cancer, and it is generally believed that cancer was in the family. Dr. Baudouin has lately published in the *Gazette Médicale de Paris* some clinical remarks on the death of Napoleon I., and the conclusion he arrives at, apparently on perfectly reasonable grounds, is that the great Emperor suffered from an ulcer of the stomach, which caused death by perforation. Undoubtedly hæmatemesis was present as a symptom, and at the autopsy there was no hypertrophy of the liver nor any signs of cancer, but a gastric ulcer which had perforated was found near the pylorus. The whole controversy exemplifies very clearly the extreme difficulty of correcting a 'mistake of this kind. It will be remembered that Napoleon's last illness was of about four years' duration, and this time would fit in with the diagnosis of cancer, though it is undoubtedly true that a competent authority diagnosed chronic hepatic disease and later abscess of the liver; but Dr. Baudouin believes this to have been a peri-hepatitis due to extension from the existing ulcer of the stomach.

#### The Cultivation of the Dragon-Fly.

ACCORDING to the reports of an experimenter, the time occupied by one dragon-fly in consuming 800 mosquitoes extends over sixty minutes. It is not stated for what length of time this useful fly can continue its process of destruction, but we learn that the proposal has been mooted to breed dragon-flies on an extensive scale with a view to finding out if their numbers cannot be so increased as to justify the hope that the mosquitoes, which play such an important role in the propagation of certain diseases, may be sensibly decreased.

#### Political Control of Hospitals.

THE superintendent of one of the most important hospitals in New York has suspended nearly 200 attendants, from March 1st up to May 1st, for intoxication. The male and female attendants apparently celebrate the advent of their pay-day by indulging unduly in alcoholic beverages. It is certainly an intolerable injustice that the political system of New York should be responsible for the appointment of drunken and disorderly attendants to an institution where their vicious behaviour inflicts on the suffering sick the additional misery of being compelled by their misfortunes to remain in an abode that must

appear at times to be, in more senses than one, a perfect Bedlam. A writer in the *Post-Graduate*, for this month, very properly says that if ward nurses are appointed because they belong to a political organisation, and can be relied upon to vote the "straight ticket," then a fitting motto to be placed over the wards would be "All hope abandon ye who enter here."

#### Acute Cardiac Failure.

THE subject which Sir Richard Douglas Powell chose for the subject of his Cavendish Lecture, which we publish elsewhere, is one of very present interest. There is a general impression that heart disease is more prevalent now than formerly, but this may be due to the close study which has been made of cardiac lesions, especially those which supervene suddenly and determine acute and even fatal symptoms. Our readers will find in this lecture many useful suggestions in regard to the prevention and treatment of this disastrous category of lesion. The public have still to be educated to the understanding that athletic pursuits, this frequent cause of cardiac breakdown, cannot safely be indulged in to an unlimited extent by every lad indifferently, and ought always to be conducted under some sort of medical supervision. There is often no warning of the mischief that is being wrought, and its extent often only becomes appreciated when the harm has been done, hence the necessity for practitioners to use their influence to avert impending disaster. The conditions under which injury to the heart may result in the young differ in many important respects from those which menace subjects more advanced in years. For instance, the young are more apt to suffer from the effects of prolonged strain, while the elderly are more exposed to risk in connection with sudden strain even of short duration. In these days of cycling, touring, and other forms of family holiday exercise, this difference is one to bear in mind, and it would be a good thing if the lecture in question could be divested of its technicalities, and popularised so as to admit of its being read and understood by the public.

#### The Viavi Fraud!

NOTWITHSTANDING recent convictions, the agents of this abomination appear as active as before; after exploiting England and Ireland, Scotland is now *en tour*, and a few days ago advertisements appeared in the Glasgow newspapers with reference to lectures to ladies which were to be delivered in the city. At one of these lectures we are informed that about thirty ladies were present, and they were treated to afternoon tea. The lecture was delivered by a female who spoke of the Viavi remedies (?) as "food for the ovaries." She fully explained the menstrual function, and went into detail with regard to the various disturbances in connection with it. In such cases the capsules and ointment required cost £3 10s.! Recently an action against the Viavi Company by a lady who had been induced to undergo the treatment resulted in a verdict with £50 damages and costs on the

higher scale. The Judge, in commenting strongly on the case, said "it was the most important that had ever come before him." In another case, where an inquest was held on the body of a child aged seven years and 10 months, a box of ointment had been used which cost £1 16s. It would seem that this Company, which has already acquired considerable unenviable notoriety, pays their agents 50 per cent. on the sales effected. Perhaps it should be mentioned that the person representing this Company in Glasgow, which remunerates their agents so generously, has been recently engaged in the laudable work of promoting and assisting with other charitably disposed Glasgow folk in supplying the poor in courts and alleys with soul-inspiring music.

THE death is announced of Mr. James Stalker, M.R.C.S., L.R.C.P., formerly of Liverpool, who succumbed to fever contracted in the discharge of his duties as medical officer of the Colonial Medical Service on the West Coast of Africa.

THE Secretary of the Royal College of Surgeons of England announces that the additions made to the Museum during the past year will be exhibited in the Council Room on Thursday, Friday, and Saturday, July 4th, 5th, and 6th. Fellows and Members are invited to attend.

#### PERSONAL.

SURGEON-COLONEL SAUNDERS, Royal Army Medical Officer at York, has been appointed Administrative Medical Officer of the Madras Presidency.

DR. ISAMBAARD OWEN has been offered the post of Principal of the University College of South Wales, left vacant by the death of the late Professor J. V. Jones.

THE EARL OF ROSEBURY will take the chair at the twenty-eighth festival dinner of the Royal Medical Benevolent College on Tuesday, July 9th, at the Hotel Cecil.

THE professional jubilee of Dr. A. R. Mackenzie, of Fortrose, N.B., was celebrated at Rosemarkie last week, when a large number of medical men assembled to do honour to the occasion.

DR. F. W. HEWITT has been appointed Emeritus Lecturer on Anæsthetics at the London Hospital, on his resigning the post of Instructor in Anæsthetics which he has held for fifteen years.

THE baronetcy conferred on Dr. William Selby Church, President of the Royal College of Physicians of London, which has already been announced in these columns, was officially gazetted on Friday last.

WE understand that Mr. Hy. S. Wellcome, principal of the firm of Burroughs Wellcome and Co., has offered to present the Gordon Memorial College at Khartoum with a bacteriological and analytical laboratory.

DR. HORSBURGH, Medical Officer of Health for Musselburgh, N.B., was the victim of a violent assault a few days since at the hands of three miners, who have since been fined £1 each. Such a mild sentence is well calculated to *encourager les autres*.

THE HON. ELLA CAMPBELL SCARLETT, M.D., daughter of Lady Abinger, sailed last week in the transport "Assaye" for South Africa, having been appointed by the Colonial Office one of the doctors to the Refugee Camp in the Orange River Colony.

THE HON. MRS. TALBOT, who was specially deputed by H.B.H. Princess Christian to perform the task, formally opened the St. John's Hospital, Morden Hill, Lewisham, on the 24th ult., with the support of the Bishop of Southwark.

DR. EVA M'CALL, Assistant Medical Officer to the Salford Union Infirmary, has been appointed Assistant Resident Medical Officer to the Birkenhead Union Infirmary. There was opposition to the appointment of a lady doctor, but an advertisement offering a somewhat higher salary brought no application from the male element.

THE important post of Medical Superintendent of the Banstead Asylum, Surrey, is about to become vacant. Attached to it is a salary of £1,000 per annum, with house rent and taxes free, and other privileges. The appointment is under the control of the Asylum Committee, London County Council, particulars of which will be found in our advertising columns.

### Galway.

[FROM OUR OWN CORRESPONDENT.]

#### THE LATE DR. KEAN AND FEVER IN ARRAN.

THE neglect to provide a doctor for Arran when the late Dr. Kean was lying ill from fever contracted in the discharge of his duty was brought before the Galway Board of Guardians by a letter from the Local Government Board in response to complaints made by the Rev. M. Farragher, the energetic parish priest of the island, who alone seems to have been alive to the seriousness of the emergency, and the inhumanity of leaving the sick doctor and islanders for a week without medical aid.

Who is to blame? In defence of the guardians it is stated "in justice to the guardians and to every member we did everything we could do to meet the circumstances though often at great trouble, and, for all that, have got this anonymous writer. A special meeting was called for the occasion, and two hours after we got the summons we met." Remarkable celerity, the guardians met in two hours, and seem to think that they deserve special credit for only this and nothing more; yet as the outcome of this "great trouble" and special activity, the islanders are left for a week without medical aid. Admitting that all the board of guardians could do at the time was to authorise the employment of a doctor, surely their duty does not end there, and they cannot disclaim responsibility. It was their business to see that their orders were obeyed.

Then there is the future to be considered; it is reported that fever still exists in the islands; it is possible that again there may be a sick doctor, and the guardians being content to say "We did all we could, we met at two hours' notice," it is probable that the doctor and islanders will again be left without medical aid. Blame attaches itself to the guardians for not holding a searching inquiry as to how it happened that no doctor was provided; but that apparently is just what they will not do. As their champion at the Board remarked, they "don't want to twist the matter and bring" anyone into it. This attitude is a distinct encouragement to a repetition of the "uncertain state of affairs," as the episode has been euphemistically termed, and the guardians do not seem to appreciate the gravity of leaving a fever-stricken community completely cut off from medical aid, except that rendered by the dispensary medical officer without a doctor.

All honour is due to the Rev. Wm. Farragher for his energetic and courageous action, but his efforts to prevent future mischief must be unavailing unless the guardians, or in their default the Local Government Board, show that even poor islanders cannot be neglected with impunity.

### Special Article.

#### DISCOVERY OF THE BACILLUS OF SYPHILIS.

A COMMUNICATION of the greatest importance was read by Drs. Justin de Lisle and Louis Jullien before the French Academy of Medicine yesterday (Tuesday), giving the result of their researches bearing on the specific bacillus of syphilis. This they claim to have discovered, and if their observations are confirmed the discovery may fairly be described as one of supreme importance.

These observers remark that although the blood of syphilitics has been found sterile by most previous investigators, it is on this fluid nevertheless that they carried on their observations, because they felt convinced that a constitutional disease like syphilis must necessarily infect all parts of the organism. They chose for their investigations cases of recently acquired syphilis in which no specific treatment had been resorted to. The blood experimented with was withdrawn direct from a vein under the strictest antiseptic precautions, and both the blood and the serum were then examined under the microscope. They found therein a rounded, granular, highly-refractile body, capable of traversing a Chamberland filter, possessed of marked mobility, of a kind already noticed by other observers. These bodies, however, never gave any result either in cultivation or by inoculation, a result which, they point out, should not excite surprise, in view of the recognised fact that the coagulated blood of syphilitics is incapable of conveying infection. This destruction of infective power is probably due to the presence in coagulated blood of a strongly anti-bacterial substance, alexine. In order to obviate the production of this substance they made use of blood plasma for their investigations, as well as of blister exudation, produced either in the ordinary way by means of cantharides, or by means of Mayor's hammer. In the plasma they found on several occasions a form of bacillus presenting the following characteristics: It is polymorphous, varying in shape from a short bacillus measuring from 5 to 8 m. in length, and from 15-100 to 3-100 of m. in width, to that of a long thread with somewhat rounded ends, not swollen into sledge-hammer shape. This organism is very mobile and moves freely in the field of the microscope. It takes all the usual stains, but it must not be dried in the flame or at a temperature above 60° C. The best stains are alcohol-ether, a solution of osmic acid, or a saturated aqueous solution of corrosive sublimate, acidulated by the addition of acetic acid. It does not take the Gram stain.

Bouillon inoculated therewith becomes turbid in twenty-four hours, and in the course of four or five days a slight cloud forms which does not spread or become thicker. Gelatine is slowly liquefied. When stabbed into gelatine it gives rise neither to the cone nor the extinguisher, the liquid in the tube is flaky, and of a greenish hue. The gelatine is not coloured and its surface remains even. On gelatine *ex botte* colonies appear in from four to five days, of a rounded outline with irregular margins, and of a greyish hue. In from twenty to thirty days the whole of the gelatine is liquefied. On ordinary gelose and on glycerinated and peptonised gelose it gives rise to a creamy, moist layer of a faint green tinge. It grows freely on glycerinated potato in the form of a whitish layer which is not dry or scaly and collects at the bottom of the tube. On solid serum it remains invisible, and does not cause liquefaction. It grows freely in amniotic liquid. It does not coagulate milk, but precipitates the caseins, leaving a fatty layer on the surface, with an alkaline reaction. It produces neither pyocyanine nor indol. Most cultures have a disagreeable, but not foetid odour.

The organism increases in length with the age of the culture, and in five or six days becomes thread-like. In ten days it becomes granular and assumes the appearance of the rounded bodies referred to above and met with in plasma, but if at this stage it is inoculated in fresh culture media it reassumes its primitive characters. In thirty days they are all granular and apparently dead, and reinoculations remain sterile, though, with certain precautions and within certain limits, the organism can be brought back to life. The most resistant part of the virus appears to be concentrated in these bodies.

Guinea-pigs into whose peritoneal cavity these cultures were injected died in from ten to fourteen days with paralysis, emaciation, and abortion. Young animals succumbed in twelve hours. Injected beneath the skin it determines the characteristic symptoms, viz., loss of hair and the formation of an indurated, ulcerated *plaque*, with enlargement of the neighbouring lymphatic glands. Post-mortem, the urine is albuminous, the spleen contracted and the liver and kidneys often the seat of fatty degeneration, the blood being invariably sterile. In the frog, death supervenes in thirty-six hours. The sterility of the blood of animals after death recalls the fact that no case has ever been recorded of syphilitic infection by post-mortem wound.

A three days old culture of this organism, placed in contact with the serum of a syphilitic subject with secondary symptoms, determined marked agglutination, a phenomenon which is not produced with the serum of a healthy subject. The inoculation of the cultures in syphilitic subjects remained in every instance without result. Lastly, the alexine contained in the serum of an animal subjected to repeated injections of syphilitic plasma became fixed by this organism, this reaction being due to the intervention of a substance, the special *sensitizer*, engendered by vaccination.

*En resumé* this organism has been found in syphilitic subjects presenting external manifestations of the disease in every case of syphilis examined and in no other cases. It agglutinates the serum of syphilitic subjects and not that of healthy subjects. Experimental inoculation in animals determines special symptoms comparable to those observed in man. It fixes the special alexin of animals vaccinated with syphilitic products, its cultures are without effect on the subjects of syphilis and, lastly, as with syphilis in man, the microbe dies with its host.

On these grounds they affirm that this organism is really the pathogenic organism of syphilis.

### Literature.

#### PARKES AND KENWOOD ON PUBLIC HEALTH. (a)

This is one of the latest, and it may be added one of the best, of the modern handbooks dealing with public health. Both authors are well-known authorities on the subject, and their plan has been to take Dr. Louis Parkes' book, which has run through five editions in ten years, and enlarge and bring it up to date. Some parts of the work we are familiar with, but others appear for the first time. The aim has been to furnish a manual for the use of medical men studying for the various health diplomas, but there can be no doubt that it will be almost equally popular among the profession generally. One chief feature is the ease of style, whereby all essential information is clearly set forth, as it were, *currente calamo*. Yet the work has been conscientiously and carefully done, indeed, the accuracy is most exemplary where such an enormous mass of details is under consideration. In a future edition a little more space might perhaps be bestowed with advantage upon the important subject of meat and meat inspection. Rheumatic fever is mentioned under the communicable diseases with the remark that "there is good reason for believing that this

disease is a specific disease and quite distinct in its origin from ordinary rheumatism. Most authorities are inclined to think that the specific bacterial origin of rheumatism has passed the region of doubt. Cancer, again, which is also alluded to under communicable diseases, might perhaps be more fully dealt with as regards the theories of its parasitic origin. The authors may be congratulated on having produced an excellent book which covers the ground closely enough for all practical purposes within the modest limit of 782 crown octavo pages. The publishing and editing of the volume leave little to be desired, while, last but not least, the price of the book amounts to the extremely moderate sum of twelve shillings.

#### MARTINDALE'S EXTRA PHARMACOPŒIA. (a)

We gladly welcome a tenth edition of "Martindale and Westcott," as the excellent work before us is usually termed. The fact that this is the second edition which has been published since the revision of the Pharmacopœia in 1898 shows the high place which it holds in the opinion of medical men, and entirely relieves the reviewer from the necessity of writing an extensive review. Since the issue of the ninth edition, a new edition of the German Pharmacopœia has been published, as well as an Indian and Colonial Addendum to the Pharmacopœia of 1898, and a Supplement to the Austrian Pharmacopœia. In preparing the present edition, the authors have, "from a pharmaceutical point of view, made a careful study of all these, prepared abstracts from them, and noted the current literature on our subjects." We note that the authors are rather sceptical as to the value of the Indian and Colonial Addendum:—"Many of the pharmaceutical processes in this Addendum appear not to have been tested practically . . . . Some of the drugs, if introduced on their own merits, might prove of service, but we question if many of them will meet with any general recognition even in India or the Colonies." There appears to be a misprint or a possible source of confusion in the head-note to the Therapeutic Index of Diseases and Symptoms:—"The remedies . . . . added in the fifth, &c., editions, are printed in italics . . . . those now added are printed in italics." If this is the case how is the one class to be distinguished from the other. As regards the value of such an index there will probably be a difference of opinion. It may be of use to many medical men, but to us it always appears to be a doubtful advantage in a work of this kind. An index which might be added to the work with great advantage is an index of drugs arranged according to their physiological action—carminatives, diaphoretics, anthelmintics, expectorants, &c. To such an index no exception could be taken, and it would be found to be of the greatest value. We trust that the authors will see their way to make this addition to the eleventh edition of their most valuable work.

#### Dublin Death-rate.

In the Dublin registration area, for the week ending June 22nd, the deaths, which are five over the average number for the corresponding week of the last ten years, represent an annual rate of mortality of 21.3 in every 1,000 of the population. During the twenty-five weeks ending on the same date the death-rate averaged 29.6. In the case of four infants under one year old the cause of death was uncertified, there having been no medical attendant during the last illness. Eighteen deaths of infants under one year old were certified. The annual rate of London for the week was 13.8, Glasgow 19.9, Paris 20.5, New York 17.8.

#### The Preliminary Examination of the Royal Colleges of Physicians, 1902.

We observe from an announcement in another column that material changes have been made in the course for this examination for next year. Intending candidates can obtain all particulars from the secretary, Mr. Greenwood Pim, M.A.

(a) "Hygiene and Public Health." By Louis Parkes, M.D., Lecturer on Public Health at St. George's Hospital Medical School, &c., &c.; and Henry Kenwood, M.B., Assistant Professor of Public Health, University College, &c., &c. London: H. K. Lewis. 1901.

(a) "The Extra Pharmacopœia." By William Martindale, F.L.S., F.C.S., late President and Examiner of the Pharmaceutical Society, and W. Wynn Westcott, M.B.Lond., D.P.H., H.M.'s Coroner for North East London. Tenth Edition. London: H. K. Lewis. 1901. Pp. 32 and 688.



## Medical News.

### Charing Cross Hospital Medical School.

PROFESSOR CLIFFORD ALLBUTT, F.R.S., distributed the scholarships, medals, prizes, and certificates to the students at Charing Cross Hospital Medical School on Wednesday last. The Dean (Mr. Herbert F. Waterhouse) read the annual report, in which reference was made to the services in the South African War of eighteen former students. Dr. Clifford Allbutt, in the course of an interesting address, attributed his own choice of the medical profession to an inordinate curiosity. Curiosity, or the desire to know things, was discouraged by our mediæval methods of education, which taught abstractions in preference to concrete things; but a child who did not show curiosity was probably an imperfect development. Medical students incessantly cultivated the plant of curiosity. Learning from books was not the generation of knowledge, but an accumulation of doubtful value, and there was no more unfortunate relation between pupil and teacher than the former's belief in the latter's infallibility. The scientific method of experimentation made the physician or surgeon not more reckless, but more careful; and in this respect there had been a great improvement during the last thirty or forty years. Heavy bleeding and heavy purgatives were grave experiments, which formerly were made with an ignorant readiness, but nowadays the complicated and delicate machinery of the human body was more carefully treated. A genius was a man who saw something which had not been seen before, and that might happen to any of them.

### St. Mary's Hospital, Paddington.

DR. CHADLE, senior physician of the hospital, presided at the annual distribution of prizes of the students of the medical school. Dr. Caley, the dean, in his report, said that during the past, as in the previous, year many senior students had volunteered for service in South Africa, with the result that sixty-two members of the medical school had been with the Imperial Forces, of whom four had died of wounds or disease. Sir Michael Foster, M.P., who subsequently distributed the prizes, scholarships, &c., delivered an interesting address chiefly with reference to the University of London. Parliament had provided in a crude form statutes for the new university, but they were dry bones which could be rattled. They had no life in them until they were clothed with flesh and blood. With regard to blood they all knew that an essential quality in blood were small round discs of a yellowish colour. (Laughter.) The University of London needed a large and ample transfusion of that sort of blood from without. Passing to the "tissues," Sir Michael pointed out that London was a great manufacturing, commercial, and industrial centre, and it was for the new University of London to show that university and practical knowledge were associated, and always ought to be associated. That was especially so with regard to the medical part of university education, because medicine had a very close relation with the practical life of the people.

### University of Dublin.

At a meeting of the Senate of the University of Dublin, held on June 27th, the following medical degrees were conferred:—

**Doctores in Medicina.**—Alfred Lewis Bartram, Alfred Heathcote Copeman, Joseph Dawson Crawford, Edward Johan Farmer, Harold Freeth, Ernest Blake Knox (stip cond.), Francis Carmichael Purser, Alfred Jacobs Rice-Oxley, Arthur Rhodes.

**Baccalaurei in Medicina.**—Alfred Lewis Bartram, Alfred Heathcote Copeman.

**Baccalaurei in Medicina, in Chirurgia, et in Arte Obstetricia.**—Gerard Irvine Davys, Cecil Edward Finny, Harold Freeth, Thomas William Harley, Francis James Strong Heaney (B.Ch. stip cond.); Ernest Albert William Henley, John William Hilliard, Arthur Norman Holmes, William Davenport Kelly, Ernest Samuel Moorhead, Thomas W. Myles, Thomas George Ferguson Paterson, Richard Atkinson Stoney (B.Ch. stip. cond.); Charles John Swayne, James Arthur Thompson, Jasper Robert Tyrreil.

The following prize and scholarship have been awarded:—Medical Travelling Prize, T. G. Moorhead. Medical Scholarship.—Anatomy and Institutes of Medicine Scholarship, William Boxwell.

### Don Miguel Colmerio.

THE death is announced (*El Siglo Medico*) of Don Miguel Colmerio, Professor of Natural History, Madrid, member of the Royal Academy of Medicine and other scientific societies. To the care and liberality of Don Miguel the Spanish are indebted for the present high state of perfection of the Botanic Gardens of Madrid, and to his many recommendations to the Government and his urgency they are largely indebted for the planting of trees in the principal streets and squares of their chief towns.

### A Botanist Censured.

A LEEDS botanist, who had supplied pennyroyal pills to a woman who subsequently aborted and succumbed to peritonitis, has been "censured" by the coroner, and advised to abstain in future from dealing with medicines of this class. Whatever the abortifacient value of this drug may be, there seems to have been little doubt as to the intention with which they were procured, and it is odd that the jury did not emphasise the "intent."

### Plague in Hong Kong.

DURING the week ending June 22nd there were 155 cases of bubonic plague with 152 (!) deaths in Hong Kong.

### Alleged Mistaken Diagnosis.

AN action was tried in the King's Bench Division last week in which Messrs. Stocks and Crossman, practising in Wandsworth, sued a licensed victualler for fees for professional attendance. The claim was resisted on the ground that the plaintiffs had failed to diagnose a dislocation of the shoulder, the result of a bicycle accident. Inasmuch as it was not denied that a careful examination of the joint had been made soon after the accident, and seeing that the defendant subsequently suffered from alcoholic delirium, during which the dislocation might very well have been occasioned, the jury returned a verdict in favour of the plaintiffs for the amount claimed, they having, in their opinion, "used ordinary and reasonable skill in the treatment."

### Death from Hæmorrhage after Operation.

AN inquest was held on the 25th ult. on the body of a child who had died from hæmorrhage consequent upon removal of the tonsils at the Clinical Hospital, Manchester. It transpired that the child was discharged from the hospital on the day following the operation, and that the bleeding set in on the following day. The child was taken to the hospital again a week later, but it was not thought necessary to detain him. It was admitted that some risk attended the practice followed at the hospital, but it was pointed out that if any complication of this kind occurred it was the duty of the parents to call in a local practitioner, a step which the parents in this instance had apparently failed to take.

### Odontological Society of Great Britain.

THE following members have been elected as Officers and Councillors for the year 1901-1902:—President.—W. A. Maggs. Vice-Presidents.—Resident: A. S. Underwood, F. J. Bennett, W. H. Woodruff; non-resident: G. Brunton (Leeds), W. S. Woodburn (Glasgow), W. B. Bacon (Tunbridge Wells). Treasurer.—C. F. Eilot. Librarian.—H. Baldwin. Curator.—J. F. Colyer. Editor of Transactions.—H. Lloyd Williams. Honorary Secretaries.—J. H. Mummery (foreign), A. Hopewell Smith (Council), W. Rushton (Society). Councillors.—Resident: J. H. Reinhardt, H. G. Read, G. Northcroft, E. Wynne Row, J. Mansbridge, M. F. Hopson, Morton A. Smale, E. D. Pedley, J. Percy Smith; non-resident: D. Corbett, junr. (Dublin), Rees Price (Glasgow), G. O. Whittaker (Manchester), T. Mansell (Birkenhead), W. A. Rhodes (Cambridge), W. Glaisby (York), J. J. H. Saunders (Barnstaple), E. A. Bogue (New York), J. F. L. Pike (Sheffield).

## Notices to Correspondents, Short Letters, &c.

**✉** CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

### WHEN DOCTORS DIFFER!

FOUR medical men gave evidence last week in a case at the Brompton County Court in respect of a claim for damages by a woman who had sustained a sprained ankle, caused, she alleged, by falling through a defective pavement light. The medical evidence in effect was:—

First Doctor: All Mrs. Sealy requires is rest.

Second Doctor: Needs two months' massage treatment at two guineas a week.

Third Doctor: Think Mrs. Sealy is suffering from dropsy rather than from the effects of the accident.

Fourth Doctor: All Mrs. Sealy requires is plenty of exercise.

The Jury: £50 damages.

JUNIOR ASSISTANT will find vacancies advertised in our present issue such as he seeks, under the London County Council and the Asylums Board.

STATIST.—Up to June last, 479 medical officers and nine consulting surgeons, 385 surgeons and 441 nurses were despatched to the front. You will find fuller details in the Report of the Hospitals' Commission.

### THE INDIAN MEDICAL SERVICE.

The *Pioneer of India*, of June 28th, in referring to the medical services, says the proposal to absorb the Indian Medical Service in the Army Medical Corps is distinctly unpopular with the Indian Services, and would excite deep and widespread dissatisfaction.

## Diary for the Week.

### ENGLAND.

#### WEDNESDAY, JULY 3RD.

OBSTETRICAL SOCIETY OF LONDON (20, Hanover Square).—8 p.m. Specimens will be shown by Dr. Lockyer, Dr. Alcock, Dr. Fairbairn and others. Paper: Mr. J. P. Maxwell: On Spontaneous Rupture of the Uterus in Placenta Prævia.

#### THURSDAY, JULY 4TH.

RONTGEN SOCIETY (20, Hanover Square).—8.30 p.m. Annual General Meeting for the Election of Officers, &c. Mr. G. Bowron will show: A Oscilloscope for measuring the Current and Oscillations in the Secondary Circuit of an Induction Coil or similar Apparatus.

ROYAL COLLEGE OF SURGEONS.—Exhibition of specimens added to Museum during past year, in the Council Chamber.

#### FRIDAY, JULY 5TH.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY (West London Hospital, Hammersmith Road, W.).—5 p.m. Ordinary Meeting. 5.15 p.m. Annual General Meeting.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.—8 p.m. Cases. 8.30 p.m. Papers.—Mr. S. Snell: A Case in which Blindness was occasioned by the Internal Administration of Salicylate of Soda.—Mr. J. B. Lawford: Further Notes of a Case of Melanotic Sarcoma of the Conjunctiva.—Major H. Herbert, I.M.S.: Conjunctival Bridge and Pouches; Union of Retrolental Folds.—Mr. S. Stephenson: Wound of Eyeball with Prolapse of Iris, Enuclation of Eyeball Twenty Days after Accident, followed Fifty-three Days later by Sympathetic Disease of the other Eye, Perfect Recovery.

#### SATURDAY, JULY 6TH.

PATHOLOGICAL SOCIETY OF LONDON (Department of Pathology of the University of Oxford, South Parks Road). 3.30 p.m. Laboratory Meeting. Dr. Ritchie: The Relation of Resistance to Tetanus Toxine to Antitoxic Power of Serum.—Dr. Martin: Inhibition of Growth of the Typhoid Bacillus.—Dr. Haldane: Haemoglobinometer.—Dr. Poynton and Dr. Faine: Arthritis produced by Diplococcus Isolated from Rheumatic Fever.—Dr. P. Stewart: Degenerations following Transverse Lesion of the Cord.—Dr. Waters: Demonstration of Tumours.—Mr. Barnard: Calcified Aneurysm of the Renal Artery.

#### TUESDAY, JULY 9TH.

ROYAL MEDICAL BENEVOLENT COLLEGE.—7 p.m.: Festival Dinner at the Hotel Cecil.

SOCIETY FOR THE STUDY OF INEBRIETY (11, Chandos Street, Cavendish Square).—4 p.m. Quarterly Meeting. Papers:—T. N. Kelyack, M.D., and W. Kirkby, F.L.S.: On Arsenical Poisoning from Beer Drinking in its Relation to the Study of Inebriety.

## Appointments.

AUSTEN, HAROLD, M.D., B.S.Lond., M.R.C.S., L.D.S.Eng., Assistant Dental Surgeon to the Dental Hospital of London.  
CADDY, ADRIAN, M.B.Lond., L.R.C.P.Lond., M.R.C.S., Resident Medical Officer to the Parish Infirmary, Brownlow Hill, Liverpool.  
CAMPBELL, P. E., M.B., C.M.Edin., Medical Superintendent of Catterham Asylum, Surrey.  
CRINION, L. A. J., M.B., B.Ch.R.U.I., Medical Officer of Blessington No. 1 Dispensary District in the Naas Union.  
EAMES, E. S. B., L.R.C.P.Lond., M.R.C.S.Eng., District Medical Officer to the Honiton Union.

EURICH, F. W., M.D., C.M.Edin., Pathologist and Bacteriologist to the Corporation of Bradford.  
FARRANT, CHARLES, L.R.C.P.Lond., M.R.C.S., Medical Officer for the St. James's District by the Taunton Board of Guardians.  
GRUGGEN, WILLIAM, L.R.C.P.Irel., L.F.P.S.Glasg., D.P.H.Camb., Medical Officer of Health of Tring.  
HILL, CHARLES A., M.B., B.A.Cantab., D.P.H.Vict., Senior Assistant Physician to the Liverpool Hospital for Consumption.  
HOOD, N. L., M.D., D.C.Cantab., Honorary Surgeon to the York County Hospital.  
LE FANU, G. E. H., M.B.Aberd., Assistant Medical Officer to the Derby Borough Asylum.  
MOORE, S. G., M.B., Ch.B.Vict., D.P.H.Eng.Conj., Medical Officer of Health of Huddersfield.  
RAY, J. H., M.B., Ch.M.Vict., F.R.C.S.Eng., Assistant Surgeon to the Manchester Children's Hospital.  
RIMMER, J. F., M.B., Ch.B.Vict., Third Assistant Medical Officer at Leavesden Asylum, Hertfordshire.

## Vacancies.

Bailborough Union.—Qualified Midwife. Salary £25 per annum. Immediate application to Hugh Clarke, Clerk of Union. (See advt.)  
Carlou Union.—Temporary Medical Officer. Salary £3 3s. per week. Immediate application to the presiding Chairman. (See advt.)  
County Asylum, Carmarthen.—Junior Assistant Medical Officer, unmarried. Salary commencing at £150, with furnished apartments, board, washing, and attendance, without stimulants.  
County Borough of Burton-upon-Trent.—Medical Officer of Health and Public Analyst. Salary at rate of £350 per annum for the Medical Officership and £50 per annum for the office of Public Analyst, and authorised disbursements.  
Cumberland and Westmorland Asylum, Garlands, Carlisle.—Senior Assistant Medical Officer, unmarried. Salary £150 a year, rising to £180, with board, lodging, &c.  
London County Asylum.—Junior Assistant Medical Officer. Salary £150 per annum, with board, apartments, washing, &c. Candidates must not be above thirty years of age, and be qualified in medicine and surgery. Forms of application to be obtained of the Clerk of the Asylums Committee. (See advt.)  
London County Asylum, Banstead.—Medical Superintendent. Salary £1,000 per annum with house, rates, taxes, and water supply free. Forms of application to be had of the Clerk to the Asylums Board, London County Council. (See advt.)  
Metropolitan Asylums Board.—Assistant Medical Officers (unmarried) at the Fever and Small-pox Hospitals. Salary £160 per annum, rising to £200, with board, lodging, attendance, and washing. Also Assistant Medical Officer (unmarried) at the Asylum, Caterham, Surrey. Salary £150 per annum, rising to £170, with rations, lodging, attendance, and washing. (See advt.)  
North Wales Counties Lunatic Asylum, Denbigh.—Second Assistant Medical Officer. Salary commencing at £120 per annum, with board, residence, and washing.  
North-Western Fever Hospital, Lawn Road, Hampstead.—Locum Tenens. Salary at rate of £160 per annum, with board, lodging, and washing.  
Owens College, Manchester.—Senior and Junior Demonstrator in Physiology. Stipends £150, rising to £200, and £100 rising to £150 respectively.  
Plymouth Borough Asylum.—Assistant Medical Officer, unmarried. Salary £150 per annum, rising to £200 per annum, with furnished apartments and board and washing.  
West Riding Asylum, Wadsley, near Sheffield.—Third Assistant Medical Officer, Salary £150, with board, &c., rising to £200. Also Fifth Assistant Medical Officer. Salary £140 per annum, with board, &c., rising to £180.

## Births.

HILLS.—On June 25th, at New Bridge House, Upwell, the wife of W. C. D. Hills, M.B.C.S.Eng., L.R.C.P.Lond., of a daughter.  
KEMP.—On June 24th, at Worktop, Notts, the wife of G. Lajus Kemp, M.D.Lond., of a son.  
KNAGGS.—On June 24th, at Camden Road, London, N.W., the wife of H. V. Knaggs, M.B.C.S., of a daughter.  
MANNINGTON.—On June 24th, at Belmont, Muswell Hill Road, Highgate, the wife of Frank Mannington, F.R.C.S.Eng., of a daughter.  
WYNDHAM.—On June 27th, at Goring-on-Thames, the wife of T. Lancelot Wyndham, L.R.C.P., L.R.C.S., of Bromley, Kent, of a daughter.

## Marriages.

BARLOW—PONSFORD.—On June 27th, at Stanford Parish Church, Kent, Herbert Cecil Barlow, M.B.Lond., L.R.C.P., M.R.C.S., of St. Ives, Farnborough, eldest son of the Rev. T. Disney Barlow, of Blaby, Leicester, to Muriel, second daughter of the late Rev. W. Ponsford, late rector of Stanford, Kent.  
DYBALL—KNIGHT.—On June 27th, at St. Mark's Church, North Audley Street, London, W., Brennan Dyball, M.B., B.S., F.R.C.S., of 47, Queen Street, Exeter, to Evelyn Maud, youngest daughter of Sir Henry E. Knight, of 41, Hill Street, Mayfair, and Stain Hill Park, Hampton.  
GALLWEY—GORDON.—On June 22nd, at St. Patrick's Church, Soho Square, by the Rev. Dean Vere, Colonel Sir Thomas Gallwey, B.A.M.C., to Maud Margaret Howard, widow of the late Captain C. W. Duff Gordon, Royal Artillery.  
WATSON—RANKIN.—On June 27th, at St. Andrew's Church, Boshford, George Trustram Watson, M.A., M.B., B.C.Cantab., F.R.C.S., of Hastings, to Dorothy Nora, eldest daughter of Hugh Rankin, Esq. J.P., of Boshford, Essex.

# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXIII.

WEDNESDAY, JULY 10, 1901.

No. 2.

## Original Communications.

REMARKS ON THREE CASES  
ILLUSTRATING

### DIRECT INFECTION WITH THE BACILLUS TUBERCULOSIS. (a)

By STANLEY BOYD, M.B.Lond., F.R.C.S.,

Surgeon to Charing Cross Hospital and the Brompton Hospital for  
Consumption and Diseases of the Chest.

CASES of direct infection with the bacillus tuberculosis are very interesting, but they are by no means common. In many cases there is nothing to do but theorise as to how infection takes place. For example, bacilli are found in the bronchial glands; on searching through the lungs very carefully, and through the mucous membrane of the respiratory passages draining to the bronchial glands, no lesion may be found. How, then, did the bacilli get to these glands? It is inferred that they passed through the mucous membrane of the pulmonary tract somewhere or other, leaving no primary lesion at their point of entry, or if there was any little disturbance during their passage, that it completely subsided, and left no post-mortem evidence. In the following cases there is no need to theorise at all; the inoculation of the bacillus tuberculosis at certain points in man is clear, and in one of the cases the course of the disease can be followed most admirably.

The first case now shows nothing beyond a normal scar. It was that of one of the nurses, who, in March or April, 1900, was carrying a tray of used spittoons; she fell, and a broken spittoon made a clean cut on her left wrist in front of the radial artery. It healed readily, but not soundly. In about a fortnight the dressing was taken off, and a scab was left. When this was removed a little central hole was found in the scar, and from and around this, redness and infiltration of the skin slowly spread. The soreness then became more marked, and the central hole remained until August. At that date she had an area of thickened skin the size of a fourpenny piece, red, dry, and somewhat warty on the surface, with a well-defined edge. The glands were not affected, and there was no evidence of spread of the infection to the lymphatics of the forearm; the whole case would be summed up by saying that she had an inflammatory thickening of the skin at this spot. On cutting it out completely, and bringing the edges together, the little wound healed by first intention, and she is now perfectly well, and has had no trouble since. Microscopic sections showed that the disease was the result of infection by the tubercle bacillus.

The next case, a lady whose age was about thirty-five, had been suffering for many years from chronic phthisis in the right lung. During an exacerbation

of her phthisis—with much expectoration, which she always received upon a handkerchief—she caused a slight abrasion with a lump of sugar on the extensor aspect of the first phalangeal joint of the right index finger. That abrasion never healed, and, although no microscopic examination was made of any of the parts removed, the clinical course renders it practically certain that this was because tubercle bacilli were inoculated from the handkerchief upon the sore. For some months no attention was paid to the sore; finally, she saw a surgeon, who rang the changes on cod-liver oil and iron, and iron and cod-liver oil. That went on for a considerable time, and no improvement took place; on the contrary, the disease was spreading in a most characteristic way. The first thing noticed was, that some months after the infection a considerable swelling formed somewhat acutely in the situation of the internal supra-condyle glands. Probably there was a mixed infection of the glands, septic or pyogenic as well as tuberculous. No suppuration occurred, however, and after a time these swellings subsided, though not completely. Next she noticed an elongated patch of infiltration just below the elbow, over which the skin was adherent and reddened round the radial lymphatics. Next a similar patch formed on the dorsum of the hand, over the second interosseous space, which ulcerated slightly. The last result the patient noticed was a small mobile lentil-like subcutaneous nodule on the ulnar side of the olecranon process; it seemed obviously to be in some lymphatic vessel. She had in addition two or three enlarged lymphatics behind the pectoral muscle. This case shows the way in which tubercle spreads by the lymph path from an evident primary lesion to the first and second group of glands above it, and, what is uncommon in the skin and subcutaneous tissue, there were here and there in the course of the lymphatics small foci of tuberculous lymphangitis, due to arrest and growth at these spots of bacilli. It is interesting to note that they did not appear until after the lymphadenitis, which probably slowed the circulation in some lymphatic vessels.

Under ether the edges were excised and the base of the primary lesion scraped, pure phenol was applied, and the wound dressed with iodoform. All affected glands, patches, and nodules were excised. Everything united by first intention except the finger; that did not heal, in spite of frequent and free applications of pure carbolic and iodoform. Ultimately it was completely excised. It then healed slowly but soundly—some sixteen months after the first operation. During most of this time fresh little shot-like nodules kept appearing along the course of the radial lymphatics. One by one they were excised under cocaine, seven or eight such operations being done. Once or twice an operation was repeated for recurrence *in loco*, possibly because the first excision was incomplete, for after the production of cocaine oedema all evidence of the little

(a) Delivered at the Hospital for Consumption and Diseases of the Chest, Brompton.

nodule, to sight or touch, was lost. The patient, fortunately, was plucky and determined, for the course of treatment was long and especially trying to one in feeble health. She has now been free from recurrence for more than eighteen months, although she has had pleurisy and some advance of her chest trouble.

The lessons to learnt from these cases are :—(1) That timely excision of tuberculous sores is the proper treatment, and (2) that with patience and perseverance the disease may be arrested even where it has got a long start. It is, however, only fair to point out that in the second case the patient, though liable to tubercle, was evidently resistant in a fairly high degree.

The next case is one of direct infection of a tendon-sheath with tubercle bacilli in the person of the post-mortem porter (æt. 62) in this hospital, whose duty it is to stain the sputum for examination. After employing a steel pen to spread some sputum known to be virulent, upon a cover-glass, he left it projecting beyond the edge of the table, and brought his hand forcibly against its point. The nib was driven into the proximal end of the flexor sheath of the ring finger. This occurred in the middle of June, 1900. He immediately tried to run fuming nitric acid into the wound caused by the pen, and no doubt he disinfected the surface by that means, but not the depths. A hard lump gradually formed in the palm, and extended down along the ring finger, which became flexed, stiff, and painful. He was treated by means of a palmar splint, and was sent to Brighton for some weeks, but he got no better. The finger became contracted, and the middle and little fingers also were coming down into the palm. A long, low, tense swelling occupied the whole length of the flexor sheath of the ring finger. The diagnosis was obvious; it was a case of tuberculous teno-synovitis. The treatment was equally clear. The man had had the advantage of the best hygienic condition which could be provided for him; he had been to the seaside with nothing to do except to look after himself and get well, but he had got steadily worse. The complete removal of the disease was urgently necessary. Six months after the operation extension of the finger is somewhat limited by the long longitudinal scar on its palmar aspect, but he has fair and very useful movement, and he is perfectly free from recurrence. The prognosis of tubercle gets worse as age increases, and therefore this result may be considered very satisfactory. A section of the granulation tissue removed shows "giant-cell systems" in large numbers and great perfection.

## TYPES OF INDIGESTION AND THEIR WIDE CORELATIONS.

By WILLIAM H. PEARSE, M.D. Edin.,  
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In an out-of-door dispensary view and treatment of disease, though we lose the advantages and control of the diet, of the exact administration of drugs, of the minute watching of the course of cases, and of the final post-mortem revelations which hospital practice gives, yet, on the other hand, we see disease over a wider area, in its inception, evolution, and gradations; we see disease in the delicacy of blendings and corelations; a dispensary clinique takes us towards the springs of the more final forms or streams—the nomenclatured diseases. A love for the out-patient room of the hospital will not a little aid in teaching the student—young or old—the largeness of the field of medicine, and prevent a

calamitous conviction of the completeness of his knowledge. A geologist or botanist does not, in general, expand to his sciences if he confine his work to books and museums; he is greatly benefited and expanded by wide field excursions; the out-of-door clinique may be looked on as a field excursion into the regions of disease.

I do not know any field more educational and expanding toward wide and just generalisation than that presented by the very complex and widely correlated symptoms which come to us under the name of Indigestion.

This is not only true in relation to symptoms and their varied corelations, but no less so in relation to the profound and varied physiology and pathology of the great organic vital tract, extending from the mouth to the rectum. The very foundations of the living cell and animal are involved. But although we cannot yet solve the complex bio-chemical problems involved in Indigestion and in its disturbances, yet a great and good empirical knowledge and practice may be attained.

I propose to view Indigestion on the side which is presented in actual practice, and not to attempt the difficult and complex bio-chemical study. For this purpose I have gone over my notes of fifty-four cases occurring during the past five years.

Niemeyer says :—"Jaksch and others have given us statistics of its (chronic ulcer of the stomach) frequency at different ages, and in different employments, &c. In the accounts of 2,330 post-mortem examinations, Jaksch found round ulcers mentioned fifty-seven times, so that to about every twenty bodies there was either an ulcer or a cicatrix. Milligan, Brinton, and others, come to similar conclusions."

Such a proved frequency of ulcer of the stomach will always compel the most serious attention to seeming trivial complaints in young adults, involving pain at the epigastrium after taking food, vomiting after eating, &c., but, on the other hand, the great number of young women who come with epigastric pains after eating, and which are relieved by vomiting, and the rapidity with which most of such cases recover has forced me to view the greater proportion of the seeming cases of ulcer of the stomach as neuroses, and I have been the more forced to this view because such seeming chronic ulcers of the stomach have wide and varied general correlated or associated disturbance of other functions. The epigastric pain and vomiting bring the patient, but the doctor will at once see that there often exists a wide and varied disturbance of different functions, which appear to be in part the foundation or essential corelatives of the stomach trouble. The rapidity of recovery of many, under a treatment not mainly directed to the stomach, but toward correcting or balancing general conditions, seems to confirm my impression that often these cases, with the most pronounced symptoms of pain at the epigastrium after eating, and which is relieved by vomiting, are neuroses.

In young women, at the period of the full evolution of their being, we can never afford to overlook the waywardness of a great variety of neuroses, with symptoms as "variable as the shade by the light-quivering aspen made."

I will shortly summarise the symptoms of the series of cases now under analysis; we shall be carried, both in the causation and corelations of Indigestion, not a little away from the stomach into wide general conditions; and such should have a due influence on our treatment.

*Type of Pain.*—In the fifty-four cases, most referred the pain to the epigastrium only, eight to the epigastrium and back, eight to the epigastrium

and left infra-axillary region, two to the epigastrium and sternum, three to the sternum only, and one to the left I.A.R. only. Such a wide area of pain, and involving nerve distribution from the medulla, the dorsal spinal cord, the great solar plexus, &c., carries us into wide correlations, and helps to correct that narrowing finality of pathology which the words gastric ulcer tends to foster.

Thirty-five said that the pain came on immediately after eating, two in five minutes, seven in ten minutes, one in fifteen minutes, five in thirty minutes, and three in one hour after eating.

Of those recorded, the pain lasted half an hour in three cases, one hour in six cases, two hours in nine cases, "hours" in three cases, and all day in five cases.

Vomiting was present in thirty-four cases; ten vomited blood, twenty-two "bitter" (bile?), and nine "sour." Twenty cases said that vomiting gave relief to the pain, four said that the pain was relieved by belching wind, two said that the pain went off by itself.

All the fifty-four patients were females: thirteen cases were in those between 14 and 20 years of age, nineteen between 20 and 25, ten between 25 and 30, three between 30 and 35, four between 35 and 40, two between 40 and 45, and three between 45 and 50.

We know that gastric ulcer mostly occurs in young women; but on the other hand, when we remember the vast "potential" of "energy" involved in the stomach and its related nerves and glands, transforming in the earlier stages crude food into living bioplasm, and doing this throughout a whole lifetime,—we shall be prepared to expect the nerve centres of the stomach to show a great variety of neuroses; we might fairly expect that the symptoms of gastric ulcer and of the varied neuroses would often commingle and not be distinguishable with any certainty.

Fourteen of the cases showed other well-marked neuroses or neuralgias; two were anæmic, one had urticaria, and five had a family history of phthisis. I have on former occasions shown that Indigestion is correlatable and often atavic with phthisis.

The menses were natural in twenty-two cases, absent in four, scant in four, profuse in one, congenitally absent in two.

There was thus not much disturbance of the menstrual function, not much correlation between the Indigestion—ulcerative or neurotic—and the menses.

The bowels were costive in twenty-nine cases, extremely costive in two, natural in thirteen. By costive is meant an action once in from three to five or six days. This costiveness seems to be very fundamental in such cases; it is remarkable that the great organic tract should be deficient in energy and function in young women, coincident with the evolution or development of the body in general, with the evolution of the sexual and nervous systems, with, in short, the evolution of the fuller being of the individual. The deficient action of the organic *primæ viæ*, thus coincident with and correlating with the general full evolution of the individual, has its roots in the widest general conditions, in the conditions of the blood, cells, and nerve energy of the general bioplasm and nervous system; on the other hand, the deficient action of the great glands and organs of the *primæ viæ* reacts injuriously on the whole system—blood, cell-contents, and nerve centres; the costiveness, the inadequate action of the *primæ viæ* is part of a vicious circle; other parts of that circle are the Indigestion, the fæcal smelling breath, anæmia, palpitations, &c.; in somewhat figurative language, the whole system seems poisoned by a somewhat suspended metabolism of the organism. The word "costiveness" is apt to close our

view from the wide and deep generic causation and correlations of the symptom.

In a large proportion of the cases where the Indigestion is associated with sluggish *primæ viæ* and anæmia, the ancient pil. aloë. et fer. taken at bedtime, or on alternate nights, as needed, followed in the morning by a moderate draught of Carlsbad or Fredrickshall water, will effectually restore the patient, and the indigestion and seeming ulcer of the stomach will, in many cases, vanish. I usually advise the juice of a third or half a lemon to be drunk in warm water at bedtime, or the lemon juice may be squeezed over the food at meal times. The lemon juice is far best taken without sugar. (a)

I am not here stating orthodox rules for the treatment of established gastric ulcer, but indicating general principles applicable to a great proportion of those with epigastric trouble and its correlated conditions.

*Wasting.*—Out of the fifty-four cases, two were appreciably wasted. Even in chronic cases, with vomiting of food nearly every day for a year, the patients have not been appreciably wasted.

*Duration of Cases.*—Two had been ill, off and on, for six years, two for five years, one for four years, three for three years, one for two and a-half years, three for two years, one for one and a-half years, and eighteen for one year, one for eight months, six for six months, one for four months, eight for three months, one for two months, six for one month, and one for one week.

*Intervals of Acuter Attacks.*—Acuter attacks in the course of chronic cases usually happened with intervals of from a few weeks to from three to six months. Thirteen had had former acuter attacks; eleven of these had had two or three or several acuter attacks.

I cannot, with a confident finality of diagnosis, assert that the above-stated series of cases were "chronic gastric ulcer"; the neurotic type was often very obvious, and one is far more impressed with this view when in contact with the patients, than any description can convey; there exists, if I may so term it, a peculiar *aura* round about neurotic cases which no words can express, but which is very light-giving in diagnosis. The true Artist catches a something in the scene which is the soul of his picture, but which cannot be described; and so it is with the evolving neurotic young woman; the essential diagnosis lies in a general estimate of many symptoms, which the physician instantly observes, and rapidly and rightly generalises. The right diagnosis and treatment of many cases of Indigestion in young women, will make one feel the force of Herschel's words that, "humility of pretension and confidence of hope become the true philosopher," and physician.

As examples of rapidly relieved cases, A. P., f., set. 40, said that for two years she had suffered pain at the epigastrium after taking food; the pain came on one hour after eating, and lasted two or three hours: then she vomited and found ease; the vomit was bitter; she was very costive. I ordered a mixture of bis. carb., soda bicarb., and lactopeptine; also Fredrickshall water in small doses, to be drunk diluted with warm water, daily before breakfast. In three days she was well, and has remained well.

Miss C., set. 25, a schoolmistress, said that for three years she had suffered pain at the epigastrium after taking food; the pain came on one hour after

(a) Eastern people are far more intelligent than are Western in matters of food and drink. It is quite common in the West to find ladies who think—often, alas! having been told so—that the "mucous membrane of their stomachs are so delicate" that they dare not eat raw fruits or adequate vegetables! It is difficult to conceive a Native of India refusing to use lime juice, tamarind, or other fruits. The experience of thousands of years has made the Native wise in many of the great matters of health and life.

eating, lasted one hour, and was felt also in the back; the pain frequently passed off with belching of wind; she suffered pain also in the right supraorbital nerve; she said that she had been anæmic a few years ago. Menses regular, not costive. I ordered a mixture of muriatic acid, quinine, tinc. calumb, and tinct. zingib. fort. Meeting this lady three years afterwards, she told me that she was quite well in three days with the use of the medicine, and had remained well since.

The first case was probably mainly relieved by the Fredrickshall water restoring an activity of the whole tract of the *primæ viæ*. The complex yet harmonious molecular constitution of the natural mineral water seemed to have given, through the great intestinal tract—the fundamental *primæ viæ*—a renewal of active “energy” to the bioplasm of the whole system. In the second case perhaps the mineral acid, tinctures, and quinine stimulated the actions and functions of the stomach; but here, too, the drugs must have acted through the whole bioplasmic and nervous systems. It appears to me wiser to submit to such vague and general hypotheses than to assert a dogmatic and verbal finality of a bare chemical therapeutic action and cure, or one based on a germicidal cure. The Indigestion in neither of the cases was an affair of the stomach; we have to cast our view far around in biology and pathology for the true connections and correlations of the most “simple” (P) cases. Nor should I exclude, in the relief of such cases, the “mental therapeutics” of the physician who brightly lifts the mental modes of the patient into the realm of hope.

These two cases are taken from a long list of similar ones. I should in such, and other cases in general, tell the patients never to look at the often pernicious printed sheet of what they may, and may not eat, for these printed diet sheets too often tend to keep the patients' mind in a state of anxiety, suspense, and needless worry. As a very general rule the patients should eat what they most fancy, and what they find to agree, not excluding vegetables, potatoes, fruits, and often with great advantage they may take pickles and malt vinegar.

I would illustrate the generic type of Indigestion, and the general involvement of the whole system by an abstract of a few cases.

L. C., f., æt. 15, had never menstruated; was a tall, pale girl; for over a month she had suffered pain at the epigastrium, coming on half an hour after eating, and lasting one hour; the pain usually “went off of itself,” but on some days she vomited.

G. T., f., æt. 35, had very profuse menses, which appeared every two weeks; extremely costive. For four months has had pain at the epigastrium, which lasts two hours, immediately after eating; then follows bitter vomit.

In these two cases the indigestion correlated with disturbed menstrual function, and both cases were probably neuroses.

S. G., f., æt. 45, had had a large family; had nursed her children; was a fine-limbed and mentally superior type of woman. For six months had suffered from severe pain at the epigastrium after eating, the pain extended around the left side and over the lower dorsal vertebræ. Under ammon. bromide and t. cinchonæ co. she was quite well in three weeks, and has remained well for two years. Liberal and varied diet was allowed. In lieu of a restricted milk diet, or of any “special brand” of whiskey, wine, or stout, I ordered her to take a walk out daily in the sea-breezy park.

M. G. M., f., æt. 47, had pain at the epigastrium immediately after eating, and which lasted from three to four hours; then she vomited “sour;” always costive menses; appear once in about six or eight

weeks, never had bleeding piles. She said that she never suffered indigestion until she received a great shock, her son being killed in a railway accident. It is impossible to exclude the “shock” as a very real part of the complex and wide correlations of this woman's “indigestion.” The case seems light-giving and suggestive as to the great place of nerve influence.

M. F., f., æt. 27, an intelligent, well-grown, single woman, said that for several years, on and off, she had “burning” at the epigastrium “like a coal of fire.” Is well, now and then, for weeks together. For two years past the epigastric pain and burning have been pretty constant; the painful sensations are worse after food. She says that the “burning” at the epigastrium is a good deal relieved if she make her corset press in and “support” that region. Is not costive; menses regular. I have treated this case on varied orthodox drug paths without much benefit; she also has at times been on a restricted milk and rice diet. I have also used with her the most encouraging “mental therapeutics.”

I dare not “magisterially assert on nature” in this case; but am more inclined to view the symptoms as neuroses rather than “chronic ulcer.”

A. N., f., æt. 23, a refined and intelligent woman, of nervous temperament, said that she did not “run off” till she was six years old; she had suffered pain at the epigastrium and in the left side of the abdomen during the past eight years. Seven years ago she was treated in a London hospital for gastric ulcer. The pain comes on at once after eating and lasts all day; the pain also comes on when she gets up in the morning. Is costive; vomits “sour,” and sometimes “bitter”; has sour taste in her mouth; has never vomited blood; belches with flavour of rotten eggs. She is worst at the monthly periods, but is quite free from “indigestion” when pregnant; has had three children. During eight months I treated her with various drugs—bismuth, lactopeptine, and cocaine; also with combined muriatic acid and pepsine; also byzini. The bowels were kept open by pil. rhei. co., and sometimes by Carlsbad water. The diet was sometimes restricted to milk, rice, custards, &c.; at other periods a freer diet of fish was given. The patient would now and then be better for a week or two, but relapsed. My eight months treatment was unsuccessful. It is fair to say that this woman had chronic gastric ulcer or gastric catarrh, but these words or names are apt to have an unjustly narrowing influence on our pathological conceptions. Her rickety childhood, her refined type, physically and mentally, the indigestion being worse at the monthly periods, its absence during pregnancy, all point to the widest and most general neurotic base. Though obliged to carry out the orthodox treatment, I did not omit more general means, such as making her go out for a walk daily, and sending her off for some weeks for change of air. The case certainly enlarges one's view of the wide correlations of indigestion, neurotic or ulcerative, and does away with the narrowing limits which names are apt to impose.

M. E., f., æt. 19, a well-nourished, spirited country girl, came for pain at the epigastrium lasting two hours after eating, then she vomited “bitter and sour,” with relief to the pain; very costive, menses regular. She said that she had suffered “indigestion” for two years, and that it followed after a “fit.” She never suffered prior to the fit. Another young woman, æt. 20, had been three years under different medical men, including three months in hospital on an exclusive milk diet. She vomited, more or less, frothy blood two or three times a week. No treatment gave relief. She said that her illness commenced shortly after her tonsils were excised. I

should be very far from pooh-poohing a possible causation between the excision of the tonsils and her subsequent stubborn disorder of the functions of the stomach. The tonsils have great, and as yet unknown correlations to the entire system, nervous and bioplasmic. I think that the beautiful guillotine is far too often used.

A woman, æt. 25, had noticed a correlation between her frequent attacks of urticaria and the epigastric trouble.

The following case lately under observation seems light-giving. R. S., f., æt. 34, a refined and conscientious type of woman, said that for three years she had suffered pain at the epigastrium, which came on one hour after eating; it was a "sinking" and "gnawing" pain; now and then the pain was sharp, and extended round the left side and over the lower dorsal vertebrae. The pain lasted two or more hours; the pain went off associated with rumbling in the bowels, the pain could be relieved by eating or lying down. Costive, and occasionally vomits "bitter." I ordered a mixture of acid. mur. dil., ℥ xv., liq. morph. mur., ℥ v., glycer. pepsine, ℥ xxx., to be taken three times a day after meals. She could take any food she preferred, and take tea if she liked. The patient was entirely relieved before the end of a week's treatment, and has remained well.

Trousseau taught us the value of small doses of morphine in combination with muriatic acid. But to venture an hypothesis, may I say, as an explanation of the success of such treatment, that the morphine would allay pain and hinder secretion, thus resting the secretory cells and their nervous mechanism. Meanwhile, the muriatic acid and pepsine would carry on digestion, and the organism would not suffer from the defective nutrition consequent on the non-digestion of sufficient food.

Improved nutrition would react on the secretory cells and help their recovery, so that they could soon resume their normal activities.

The examples will, I hope, be of use in showing the width of pathological relations of "Indigestion"; treatment also must embrace a wide general view; no disease, more than epigastric indigestion, opens to our view the widest correlations and interdependence of function, both in health and its disturbance—disease.

During over twenty years' wide observation I have not known of a case of fatal gastric ulcer.

#### TREATMENT.

In a hospital we see disease in its more final stages and forms; in hospital cases and practice, gastric ulcer is usually easily recognisable, and, no doubt, the orthodox treatment of the day, rest, opium, exclusive milk diet, ioe, &c., is called for, and in our present light, right; but in dispensary practice we often see disease in its evolution and growth, in the delicate deviations of its onset, and in the wide deviations of its earlier roots. Thus it happens that orthodox and routine rules of treatment will not be a measure of, or meet the conditions of, the varying types of cases which nature presents.

In thirty-four of my cases of indigestion I began treatment with muriatic acid, quinine and pepsine; the greater proportion did well, but in thirteen of the above I had to abandon the treatment and to give bismuth, sodæ bicarb. and lactopeptine; even then, in several, I failed to give relief. Malt extract was given under both classes of treatment. In eleven, I began with and continued the bismuth, &c., treatment. I have seen, in a few cases, a rapid relief both from the acid and bismuth treatments, but in some cases there was much failure to relieve the patients.

A paramount aim was to greatly stimulate the whole *primæ viæ* by the pil. aloë et. fer., or by a

mineral water, by a digestible but varied diet; by the use of lemon juice as a drink. In a few that I kept on an exclusive milk diet, temporary benefit would happen, but in general the patients were not "cured" by a milk diet, the relief of the pain would be for a week or two only. I incline more to a light and varied diet—fish, the best vegetables, and fruits. I am sure that lemon juice, drank daily in cold or warm water, is a mighty good thing, both for the young and old. The semi-scorbutic, anæmic, vitally expended Native of India will beseech that he be given lime juice or tamarind; under its use his ulcerative chronic diarrhoea and dysentery will often cease; his whole system will be benefited, and thus, his bowel complaints will cease, and, presumably, the extensive ulcers of his big gut heal. It is a most limited view of pathology and of therapeutics to treat the Natives' dysenteric-diarrhoea by remedies directed to the bowels only; his dysenteric-diarrhoea has a deep-down generic base; similarly, the young women of the poorer classes in South Britain, whose action of the *primæ viæ*, as shown by costiveness, by the fæcal fœtor of the breath, by the often coexisting anæmia, by the indigestion, by the chlorosis, &c., must be treated on the widest general principles.

Both in the Natives of India suffering from extreme loss of appetite, anæmia and often chronic diarrhoea, and with young Europeans suffering from epigastric pains, sluggish action of the *primæ viæ*, I have a great many times put them on the right path towards recovery by yielding to their fancies for special food; "sours," i.e., vinegar, pickles, lime juice, tamarind, &c., may often be given with great advantage, especially when asked for. I have often seen patients who have been kept on a strict and limited diet, e.g., milk, mutton, &c., and who have been debarred fruits, vegetables, onions, tea, &c., get well almost at once on giving them a greater liberty. I never ignore the possibilities of neurotic influences in "indigestion," and aim to look all round for the correlations and greater channels of the case.

No one would lose sight of the beautiful researches of the bio-chemists and physiologists on the great organs and glands of the organic tract; but there is another field for the observant practitioner, viz., the experience of mankind throughout the ages, and, when judiciously interpreted, the expressed desires of our patients. Empiricism, submissively observed and carefully studied and sifted, is often a right path for safe practice.

## THE OPERATIVE TREATMENT OF DEFORMITIES OF THE ELBOW-JOINT RESULTING FROM TRAUMATISM. (a)

By DR. SAMUEL LLOYD,  
Of New York.

THREE things were recognised in fractures into the elbow-joint: First, it is not always possible to tell, even under an anæsthetic and with the most careful examination, just what the joint injury is. Secondly, it is not always possible to replace the fragments, even approximately. Thirdly, ankylosis will result in certain cases in spite of any plan of treatment that may be adopted.

All fractures involving, or in the vicinity of the elbow-joint, should be examined under anæsthesia,

(a) Abstract of paper read before the New York Academy of Medicine, April, 1901.

the fragments placed in apposition, and the limb dressed in a position that enables the operator to retain them in place most efficiently. Personally I prefer flexion. I am decidedly opposed to passive motion, so much advocated by the older surgeons, believing that this caused an increase of callus and consequent diminished range of motion. Any passive motion in an elbow-joint, until after the bone is firmly united, is meddling surgery. If, when the splint is removed, motion does not return promptly by active motion (an attempt on the part of the patient to use it regularly), the deformity should be examined. If moderate passive motion succeeded, then we have to do with simple adhesions. If the joint does not yield under an anæsthetic, then the difficulty is probably due to obstructing callus or to a displaced fragment. I believe the ankylosis or limitation of motion to be due to bone and not to fibrous adhesions, provided there have been no septic complications. While my first operations and conclusions antedated the use of X-rays, they have been corroborated by an extensive use of the X-ray.

The overproduction of callus is a constant danger in the direction of producing ankylosis, and is increased by any motion of the fragments during the period of union. Provisional callus is objectionable. The bone unites in the same manner as the soft tissues, with but little granulation tissue, if firmly held together.

The X-ray has been somewhat disappointing in solving all the difficulties of fracture work, since it gives only a shadow of the real object. The X-ray, however, so frequently illustrating dislocation complications has emphasised the necessity of using an anæsthetic in the first examination of fractures about the elbow-joint.

The majority of cases of ankylosis of elbow following fracture being due to bony displacement or to callus, if non-operative measures are not successful in removing these causes, something should be done to put the bones in proper position. In compound fractures we are all agreed as to what should be done—viz., enlarge the wound and suture the fragments in position.

It is, however, on simple fracture that I would dwell more particularly. At first sight cutting into the joint and manipulating the structures about the joint, including the capsule, would appear likely to result in almost, if not absolute, fixation. Such has not been my experience, and I hold that the fear of attacking a joint surgically is largely a relic of pre-septic times.

I am enabled to illustrate the different fractures occurring in vicinity of the elbow-joint by a series of skiagraphs of cases I have operated upon. One is a supra-condyloid fracture of the humerus where the difficulty was found due to both callus and displacement. The arm had been treated at an angle 145 degrees, the condyles being carried backward while the shaft of the bone was drawn forward.

In flexion the coronoid process of the ulna struck upon the mass of callus below the more prominent projection of the shaft, while the ulna rested upon the sharp end of the diaphysis in the complete flexion. This boy had a useless arm. The projecting portion of the diaphysis was chiselled off and a new coronoid fossa was cut out with a curette until complete flexion was possible. The result was remarkably satisfactory. In spite of the extensive dissection necessary to reach the anterior surface of the humerus and the consequent lacerating and bruising of the capsule and synovial membrane, flexion was obtained almost to the full extent. The other skiagraphs further illustrate varieties of fractures about the elbow-joint, complicated with callus and dislocation, upon which I have operated gene-

rally with success. I may sum up the management of fractures of the elbow in the following words:—

(1) Examination and reduction under ether. If the latter is impossible, and it is evident that disability will result in consequence, immediate incision and dissection until the fragments can be forced into position and wired or sutured. If, however, this is still impossible, the fragments should be removed.

(2) If ankylosis or marked limitation of motion results and does not prove to be due to fibrous bands, operation should be undertaken and everything opposing the proper movement of the joint should be cut away.

When I performed my original operation in 1894, I was unable to find any records of previous operations of the kind, but now there are many. I may mention as reporting cases, Alles, "Annals of Surgery," 1897; Wight, *ibid.*, 1893; Klemm Sambheng, "Klin Vortrag," Sept, 1893, recognised possibility of the operation.

The open method of treatment was advocated much earlier in irreducible dislocations of the elbow, and it seems strange that it was late in coming into more general use in fractures.

In all my cases, twenty-one in number, the posterior incision similar to that made for excision of the joint was employed. This answered well for manipulation of the olecranon fossa of the humerus or the injuries to the condyles. The difficulty of clearing out the coronoid fossa and managing the anterior displacement was greater. I varied the incisions according to the injury. The capsule should be as carefully opened and sutured as the peritoneum. One can scarcely be too radical in removing bone; it is better to try for both flexion and extension than to stop short of removal of any obstruction. After removal of bone I flush the joint with hot normal saline solution, suture the capsule carefully, and close the wound without drainage. Rest in flexed position for one week, then massage and active motion.

## TUBERCULOSIS IN CATTLE:

### ITS SPREAD AND PREVENTION. (a)

By MR. J. P. PENBERTHY, F.R.C.V.S.,

Professor of Medicine in the Royal Veterinary College, London.

THE lecturer remarked that during the past twenty years much scientific knowledge of that disease had been acquired, but the application of scientific knowledge was not likely to be far in advance of public opinion. The value of educating the public on that subject could scarcely be over-estimated, for science had done its share by demonstrating its preventibility and the means of prevention, but the suppression of that menace to human health and agricultural prosperity must now remain with the public, whom it affects. It was now for the social economist and the legislator to apply the knowledge science had placed at his disposal. It was, however, "the man in the street" whose expressed opinion set in motion the cumbersome machinery of social economy and legislation, and he was firmly convinced that it was to the education of the public they must look for the removal of that deadly enemy. A single case of suspected plague, cholera, or small-pox, was reported with the utmost alacrity throughout the length and breadth of the land, and stringent measures were immediately adopted for preventing its spread. Diphtheria, measles, scarlet fever, &c., were all provided for by law as they might reasonably expect. Tuberculosis claimed annually for its victims in Great Britain and Ireland about 70,000 human beings—one-tenth of the total mortality in these islands, and yet, until within recent years it was allowed to pass unchallenged, and was still practically unlegislated for. That inaction

(a) Abstract of lecture delivered at Aberdeen at the instance of the Committee on Tuberculosis.



had resulted from several causes, the chief of which was the insidious progress of the malady, want of knowledge, and, beyond all, the absence of any evidence that it was preventible. Scientific men, as witnessed by their work and words, politicians, as proved by the appointment of committees and Royal Commissions, recognised the danger and indicated the methods of prevention, and even the law, by certain apologies for action, had taken cognisance of these matters; but until the public were educated to the danger and the possibility of escape, that desired safety would never be accomplished. Their main object there that day was to consider the effect of the flesh from tuberculous animals on the health of men.

He was sure that all who realised that there was such a danger would deem it a privilege to do his share in trying to avert it. It was, however, important that they be convinced of the danger, and, as far as possible, of its degree. They in Great Britain were not credited with being an impetuous people, their reason must be appealed to, but with solid basis of action, their sense of justice would rise to the occasion. It was under that conviction that he would venture to proceed to a cursory consideration of the subject, or, particularly, that part of it concerned with the flesh of tuberculous animals. The malady, which assumed various forms, and was known by many names, was invariably caused by the entrance into the body of a very minute germ or microbe, now almost familiarly known as the tubercle bacillus, and though certain states of the system and other circumstances might be essential to its growth, development, and power to produce the disease there, without the tubercle germ there could be no tuberculosis. That germ was always derived from some man or animal affected with the disease. The same germ produced tuberculosis in man and animals, and it might enter the body of either in the dust, in food and drink, and even through a wound in the skin. Though very many species of animals, including horses, cats, dogs, rabbits, &c., were liable, it was much more common in the domesticated animals whose flesh is used for food—among cattle and pigs. Of cattle by far the larger number of cases were found in dairy cows, especially the older ones. Indeed, the main factor in bringing about that incidence was the congregating for long periods indoors. Sheep which lead a life in the open air are very rarely affected. Cows in mild climates, such as Jersey where housing is little known, enjoy comparative, if not complete, freedom. In fact, overcrowding, with bad ventilation and lack of sunlight in man and animals, is accountable for the occurrence of a high percentage. But observation had over and over again proved that neither overcrowding, want of ventilation, nor general insanitary conditions alone induced tuberculosis. The tuberculous animal was the prime—the only—factor in providing the essential tubercle germ, and if we desire to prevent tuberculosis in cattle we must remove tuberculosis from healthy animals. According to a variety of circumstances associated with the mode of entry, the state of the constitution in general, or of certain parts of the body, the germ settled in some situation, and there it grew and induced the disease in the part. It became localised, and they might take it that at first tuberculosis was a "localised disease," and experience had told them that it usually remained so for a long time. The tubercle bacilli tended to remain in that part, and for some time other parts were free. In infection it might be, and commonly was, that the germ or germs settled only in one spot or resting-place, and that for a longer or shorter time only was "tuberculous." It might be that at that or a subsequent infection germs from without might have found several resting-places, and induced tuberculosis in several different parts of the body. The condition was, however, according to present interpretation, still "localised tuberculosis." While, however, the germs were active in any of these positions, they were more or less rapidly increasing in number, destroying the healthy structure of the part, and extending in that way so as to produce large tuberculous lesions, whence they might gain entrance to a vessel, and so get to the

heart, from which they were discharged into the blood stream, and, it was believed, sent over the system. When that was the case the so-called "generalised tuberculosis" existed, and it was usually regarded that under such conditions it was unsafe to say that any part of an animal was free from tubercle germs. More recent experiments, however, went to show that when such an occurrence took place the great majority of the bacilli were arrested in the lungs, through which all blood from the heart must pass. That produced in both the lungs innumerable small tubercles, the so-called "miliary tuberculosis." From that fact the lungs yielded the strongest and probably the only trustworthy evidence of "generalised tuberculosis." Absence of tuberculosis in the other organs of the body in the experiments referred to, at any rate forcibly suggested that even in the so-called "generalised tuberculosis" there was not a general distribution of the germs throughout the body of the animal. It might, however, not be inferred from this that tubercle germs might invade the body in no other way than by the blood stream. Their tendency was to spread by the lymphatics to the glands, and there, or on their way, they might be arrested and set up tuberculosis, and so contaminate many parts, some of which are removed easily, and others cannot be so removed. There was little tendency for the germ to rest and grow in the muscle or lean flesh, but the lesions might be so numerous and closely associated with the edible parts of the carcass that they could not be separated with certainty. That might apply to one lesion or many. When the lesion was in connection with the outer world, as sometimes happens when the lungs, udder, throat, intestines, &c., were their seats, the tubercle germs might be thrown off by the animal, and so become a danger to others. They were then capable of living outside the body for a long time, though they did not multiply there under ordinary circumstances, and be conveyed to healthy animals by dust or food. It was, however, well known that they were killed by subjection to high temperatures, and a very short exposure to a heat of 180 degrees F., i.e., 32 degrees under boiling point, destroyed them. The general effect of the tubercle germ on the constitution of the animal affected, apart from the destruction of the portion it invaded, was usually marvellously little. It was not uncommon to find the most extensive tuberculosis in cattle in prime condition and apparently perfect health. It would be thus seen that the flesh of animals might contain the germ, and as it was a truism "that any man or animal taking the tubercle bacillus into his system runs a risk of becoming tuberculous," there was a certain amount of danger associated with the consumption of flesh from tuberculous animals; a danger of which they urgently desire to form a just estimate. Though granting that the conservation of human health outweighed every other consideration, it need not obscure the fact that the prevalence of the disease in our herds of cattle, pigs, &c., caused an enormous drain on the resources of the stockowner. The most moderate computation indicated that between 20 and 30 per cent. of dairy cattle were affected, and in a lesser degree than young stock. The danger to the health of man through drinking milk, a real danger indeed, scarcely came within the scope of that lecture, but the stock-owner had every inducement to rid his herds of tuberculosis. In the natural order of things, however, sooner or later, this 20 or 30 per cent. of tuberculous cows, and the smaller proportion of other cattle and the pigs so affected which did not succumb, came to the butcher and the meat trade. It was that enormous impost which had to be faced, and considered by the conservators of public health and the vendors of meat. The prevalence of tuberculosis in cattle was brought to light in the slaughter of cattle for pleuropneumonia.

In 1888 a Departmental Committee sat, and going beyond the scope of their instruction, recommended that, owing to the danger to consumers of flesh, all carcasses in which existed a trace of tuberculosis should be confiscated and destroyed. The application of the tuberculin test yielded evidence of an even higher percentage

of tuberculous cattle, and with that evidence there was perhaps little wonder, that that portion of the medical world and the public, who interested themselves, should become excited, and that an idea should prevail and extend that tuberculosis in man was a cattle disease, communicated to him by eating meat and drinking milk, and that the responsibility for the human mortality rested with the Board of Agriculture. Owing to the want of system, uniformity and proper returns, the Commissioners were unable to form an opinion as to the financial results of the application of their proposed standard, so were compelled to have recourse to some returns for foreign countries. In Saxony, where the inspectors are all veterinary surgeons, and the inspection rigid and discriminating, tuberculosis was found to exist in 22,758 carcasses (being 27.48 per cent. of the whole numbers slaughtered). The whole of these, according to the practice of some authorities in this country, would have been confiscated and destroyed without compensation. In Saxony they were dealt with as follows:—Of the total number 22,758 showing tuberculous lesions, 21,062, or 92 per cent., were passed as fit for food; 1,256 carcasses, or 5½ per cent., were disposed of in the Freibank as inferior meat, at a fixed cheap rate; and the remainder, 440 carcasses, or 2 per cent. of the whole number pronounced tuberculous in a greater or less degree, were condemned as unfit for food and destroyed. The report of the chief sanitary inspector of London states that 30 per cent. of the cows which were examined under his authority contained tuberculous lesions, and he found that only 6 per cent. had to be condemned as unfit for human food. The other 24 per cent. the tuberculous lesions were removed and the flesh was allowed with safety to go into the market. He went on to advocate a system of public slaughter-houses and the marking of foreign meat. On the question of compensation to owners of condemned carcasses the Commission were unable to come to a unanimous conclusion, but he thought it probable that many present would endorse the views of the minority that the owner should receive compensation on certain conditions, and he did not think their demand would be regarded as extravagant by any who believed that the principles of compensation should be applied to tuberculosis. Though scientific investigation and common observation went to prove that the danger arising from eating the flesh of tuberculous animals was much over-estimated, no one could deny that the edible parts of tuberculous animals might contain the tubercle germs, rarely as this may be. No proof was required that inspection of meat was necessary, and, if necessary for large communities, it was necessary for the more scattered population. It should be uniform. It has been clearly shown to be wanton waste to destroy but a small portion of the flesh of most tuberculous animals. Indeed, it had been said there were grave doubts as to whether flesh cooked in the ordinary fashion ever induced tuberculosis in man. A greater danger was undoubtedly associated with milk from cows with tuberculous udders. Other countries, Belgium, Massachusetts, &c., have adopted extreme measures, probably without counting the cost or measuring the possibilities, and have had to withdraw. When it was for a moment considered that a large proportion of our six million cattle was tuberculous, that of our two and a half million cows probably more than 800,000 were affected in a lesser or greater degree, they should realise the enormity of such an undertaking. To withdraw all our milk cows reacting to tuberculin from our dairies would paralyse the dairy industry, arrest breeding, send the trade abroad, perhaps never to be recovered. And after such an attempt there were grave reasons for supposing that some tuberculosis would still exist, while the cost would be immense. He shared the opinion that the disease might be very materially reduced, if not eliminated, by rational precautionary measures. He was under the conviction that no Government would be cajoled into giving full compensation. In the meantime in the absence of compensation from the State, it appeared to him a system of mutual insurance should be adopted in which contributions should be made by the farmer who sells the tuberculous animal, by the

local authority representing the consumers' benefit in health, and by the butcher, who may or may not take the risk into consideration in his dealings, but whose burdens would be thereby lightened.

## Transactions of Societies.

### OBSTETRICAL SOCIETY OF LONDON.

MEETING HELD JULY 3RD, 1901.

PETER HORROCKS, M.D., President, in the Chair.

#### SPECIMENS.

##### MENSTRUAL MEMBRANE IN EXFOLIATIVE ENDOMETRITIS.

DR. CUTHBERT LOCKYER showed a specimen of a menstrual membrane passed by a single woman, *æt.* 19. Her periods had been normal till six months previously, when they began to be profuse, and shreds were passed; but the patient had no pain. After curetting, no more membranes were passed. He thought the condition was best described as exfoliative endometritis.

Remarks on the specimen were made by the President, Mr. Alban Doran, and Dr. Eden.

##### CYSTIC CORPUS LUTEUM.

DR. RICHARD ALCOCK (Goole) showed this specimen. The patient had had septic endometritis following labour, and for ten months afterwards suffered greatly from severe pain on the left side. Abdominal section was then performed, and the ovary of that side was removed. It contained a cyst the size of a plum, on puncturing which fluid escaped under considerable tension. It proved to be a cystic corpus luteum; in its collapsed state it surrounded a considerable portion of the ovary, the section suggesting one across the empty right ventricle. Dr. Alcock suggested that the septic endometritis after labour might have led to the corpus luteum becoming cystic, instead of undergoing its normal involution.

MR. ALBAN DORAN said that Dr. Alcock's explanation of the origin of this corpus luteum cyst was ingenious and interesting; it might quite well be the correct explanation. Certainly, suppurating cysts of the corpus luteum were known to result from septic perimetritis.

Remarks were also made by the President and Drs. Spencer and Eden.

##### CARCINOMA OF THE OVARY.

DR. FAIRBAIRN showed a specimen removed from a patient by Mr. Bland-Sutton. The pedicle was twisted. The contents of the cyst were soft, and somewhat suggested a dermoid; but microscopic examination showed that it was a case of carcinoma. An interesting point was that the tumour had a thick capsule, which was quite intact; the growth was therefore well circumscribed, and the prognosis was good. The patient had suffered from menorrhagia and metrorrhagia for some months.

DR. ARTHUR GILES said that the case possessed considerable clinical as well as pathological interest, especially from the point of view of diagnosis. He saw the patient in the out-patient department, and the history of hemorrhage going on for some months, without any very obvious cause, and of marked pain in the left side, together with the presence of a well-defined tumour to the side of the uterus, led him to diagnose extra-uterine gestation, and this was the view generally taken when she was in the hospital. An element of doubt in the diagnosis was introduced by the mobility of the tumour; he had, however, known exceptional cases, where the tumour in a case of extra-uterine gestation was mobile, even though of considerable size.

DR. CULLINGWORTH said, in reference to Dr. Giles's observations on diagnosis, that in his experience a considerable hemorrhage was not characteristic of ectopic gestation; the blood generally came away in a dribble, and was not arterial, but dark, and resembled menstrual blood. He had often found this distinction of service in arriving at a diagnosis.

Some observations were also made by the President, Mr. Alban Doran, Dr. Duncan, and Dr. Bonney.

## INCOMPLETE TUBAL ABORTION.

Dr. FAIRBAIRN also showed this specimen, removed by Dr. Cullingworth. It was a partial expulsion of a foetus, four inches long, through the fimbriated extremity of the Fallopian tube. The after-coming head of the foetus was retained within the tube.

Dr. HERMAN said that it was an interesting question what became of the tubal mole in the pre-operative days; no specimens found in museums dated back more than a recent period. He presumed that a mole left to nature became absorbed. He operated a few days ago on a patient, and removed a recent mole from one side; on the other side the tube was occluded, and adherent to bowel, and contained a gummy fluid. He believed that this represented an older mole that had become mainly absorbed.

Dr. WILLIAM DUNCAN agreed with Dr. Herman that a mole when left alone became absorbed. He operated recently for double hydrosalpinx on a patient whom he had seen eleven years before. She then had a tubal gestation which was not operated upon at the time. At the operation no trace was found of the former tubal pregnancy.

After some remarks by the President and Dr. Drummond Robinson, Dr. CULLINGWORTH gave a brief account of some clinical features in the case.

## CARCINOMA OF THE UTERUS SUBSEQUENT TO DOUBLE OVARICTOMY.

Mr. A. C. BUTLER-SMYTHE showed a uterus, the seat of carcinoma of the cervix and pyometra, removed from a patient who had had a double ovariectomy performed eighteen years previously; a large multi-locular cyst having been removed on one side, and a cystic ovary the size of a Tangerine orange on the other side.

Dr. HERMAN stated that he had had a case of carcinoma of the cervix occurring sixteen years after he had performed double oophorectomy.

Dr. HERBERT SPENCER mentioned that two other such cases had been recorded in the Society's Transactions.

Further observations were contributed by Mr. Alban Doran, Dr. Amand Routh, and Dr. W. Tate.

Dr. WILLIAM DUNCAN showed (1) a myoma with a large cystic cavity; (2) a myomatous uterus studded with a very large number of small fibroid nodules.

## SPONTANEOUS RUPTURE OF THE UTERUS IN PLACENTA PRÆVIA.

A paper on this subject was contributed by Dr. J. PRESTON MAXWELL, of China. It was the record of a case successfully treated by gauze-packing from the vagina.

Dr. F. H. CHAMPNEYS remarked that this was a valuable record of a rare occurrence, the small size of the child and the absence of causes for rupture being especially notable. He had no doubt that Dr. Maxwell had done the right thing; for in cases where the child had not got into the peritoneal cavity, gauze packing had been found to give the best results.

Dr. HERMAN believed that there was very little difference in the consistence of the uterus in cases of placenta prævia and in other cases; it had been said that a cause of "spontaneous" rupture of the uterus was fatty degeneration of its muscle fibres; but he did not believe that the existence of fatty degeneration of the uterus was established, or that it was a cause of rupture. Dr. Helme had shown that there was no fatty degeneration in the cases he examined; they were not, however, human uteri.

Dr. DRUMMOND ROBINSON said that he had had an opportunity of examining two human involuting uteri, and had found no fat at all.

Dr. HERBERT SPENCER said that he had examined several uteri where spontaneous rupture had occurred, and had found no fat. He was glad to find that Dr. Maxwell practised gauze packing, for his experience was entirely in favour of this mode of treatment, except in the cases mentioned by Dr. Champneys.

Dr. AMAND ROUTH had seen a case like the one recorded in the papers in the country; the woman, who was at the eighth month, had been in labour for a day or two and had had several hæmorrhages. He found a

placenta prævia and performed a podalic version. In the course of the night the foetus came through with a rush, and the uterus was torn through. Unfortunately, the patient died of septicæmia within a week. The cervix in this case did not appear to be specially thin, but rather presented the characters of a spasmodically contractile and undilatable cervix.

The discussion concluded with a few remarks by the President.

## EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD JULY 3RD.

Mr. A. G. MILLER, President, in the Chair.

Dr. SIMS WOODHEAD, in opening a discussion on

ALCOHOL IN ITS MEDICAL AND SCIENTIFIC ASPECTS, first alluded to the difficulty which existed in coming to any conclusion on the whole question of alcohol—a question which it was scarcely possible to approach without bias in one direction or another. We had to consider alcohol as a poison, as a drug, and as a food. It was, as all knew, a readily oxidisable substance, and was completely burned up in the body. Hence it was a producer of energy, and was therefore regarded by some as a food substance. The quantity of alcohol required to yield the requisite number of calories was, however, so great as to be a poisonous dose. It could not, therefore, be regarded as strictly comparable to other foods. It had been shown that the nutrient part of alcohol did not combine with the protoplasm of the cells of the body, as in the case of other foods, hence it differed totally from these in its properties. It was even doubtful whether it acted as a residuary food, and it seemed, like phosphorus, to have so powerful an affinity for oxygen that it diverted to its own use oxygen which would normally go to protect the body proteids from waste. In this respect it closely resembled the toxins of certain organisms, which have a similar attraction for oxygen. Its action, however, differs from that of the proteid toxins, because in process of time a certain amount of immunity is acquired against the latter, while the most prolonged action of alcohol produces not the least immunity, on account of the absence of any proteid reaction against it on the part of the cells. Alcohol was undoubtedly cumulative in its effects, and when circulating in the body along with another toxic agent, both their actions seemed to be intensified. This was seen in the case of arsenical neuritis following beer-drinking, and in other conditions. One of the most important effects of alcohol was undoubtedly in predisposing to the specific infectious diseases, and this had now been the subject of a great deal of experimental work by Abbott and others. It had been experimentally demonstrated that alcoholised rabbits were much more susceptible than normal to the poison of erysipelas, cholera, and anthrax. This had been confirmed as the result of observations made at Lille with the poisons of hydrophobia and tetanus, and it had, moreover, been proved that it was quite impossible to produce in an alcoholised rabbit any marked degree of immunity against the toxins of these diseases. As regards the virus of hydrophobia, the experience of the Pasteur Institute quite coincided with these experiments. In all these cases toxic doses of alcohol were employed, and objection might justly be taken to this, but a series of observations in Fraenkel's laboratory in Halle, in which the dosage of alcohol per kilo was less than that used systematically in the treatment of phthisis at Davos, had led to the same conclusions. The animals were much more susceptible to the toxins of diphtheria and tubercle, and, in particular, it was impossible to produce in them any high degree of immunity. These experiments were conducted with the greatest care, and he thought that we were not justified in disregarding their teaching simply because they had to do with the effects of alcohol. Its use in phthisis, especially, seemed questionable, both because immunisation of the patient—towards which all the efforts of the physician should be directed—was rendered more difficult of accomplishment, and the risk of

secondary infection consequently increased, and because it appeared irrational to administer a substance whose affinity for oxygen was so great in a disease where the respiratory capacity was already taxed to its utmost. Passing to the effect of alcohol on certain organs, Dr. Woodhead recalled his experience in the post-mortem room of myocarditis and fatty degeneration of the heart in cases of acute alcoholism. He also described recent observations which had been made on the changes in the nervous system caused by alcohol—changes exactly comparable to those resulting from the actions of other toxins—such as alterations in the staining of the Nissl's bodies, shrinkage of the dendrites, and the like, and said that if these were definitely proved they would constitute a great advance in our knowledge of the pathology of alcoholism. Another important action of alcohol was that on the thermogenetic centres. It was found, for instance, that while it was impossible by the application of external cold to reduce the temperature of a normal rabbit more than 3° C., yet if the animal were alcoholised the temperature could be reduced from 38.2° C. to 19.8° C.

Professor T. R. FRASER said that a large part of the difference of opinion as to the therapeutic value of alcohol, as well as to its dietetic position, turned on the question of dosage. Everyone knew that in large quantities, or in too frequent doses, alcohol was deleterious; but in small doses it had definite and valuable actions, in respect of which it could be replaced by no other drug. As regards its food value, it had been most conclusively proved that only the very smallest percentage was excreted, and that nearly all was burned up in the body. It was, therefore, impossible to doubt that it was an energy producer, and this very affinity for oxygen to which Professor Woodhead alluded as undesirable, was, in fact, one of its great advantages, because in the crisis of an acute illness, when ordinary food could not be absorbed, we could by the use of alcohol supply material from which energy sufficient to tide the patient over the period of greatest danger could be derived. In small doses its action upon the heart was of the very greatest value. It acted as a direct cardiac stimulant, which was easily and rapidly absorbed, quickening and strengthening the heart, and, most important of all, as the effect of the drug passed off the heart returned to its former state without the occurrence of any interval of depression. No other drug at our disposal had this action. Alcohol also dilated the blood vessels, and thereby flushed the tissues with blood and restored their vitality. Passing to its other uses, alcohol in small doses stimulates the flow of saliva without interfering with its digestive power, improves the appetite, increases the peptic secretion, and excites gastric peristalsis. It was therefore a stimulant to primary digestion, and in the widest sense of the word a true tonic remedy. As a producer of energy it had a nutritive value equivalent to that of fat. Its antipyretic action was well known and often extremely beneficial; it acted in this way by increasing the loss of heat, not by diminishing its production. In reference to what had been said as to its effect in increasing the susceptibility to specific infectious diseases, he thought that it must play an extremely unimportant part compared with other factors. In plague, for instance, the mortality among the Hindu population, which never touched alcohol, was almost 99 per cent., while among Europeans it was not more than 30 per cent.

Dr. CLOUSTON said that the place of alcohol as a cause of mental disease was undoubtedly extremely important. It was the most common factor noted in the admissions to the Edinburgh Royal Asylum—over 25 per cent. of all cases. But, after all, as a cause of insanity the neuropathic constitution was of infinitely greater consequence. In Dorsetshire, for instance, alcohol was given as a cause in only 5 per cent. of the admissions, though the proportion of insane persons to the total population was as high as in Edinburgh. The neuropathic brain, with its keen delight in art, poetry, and the gratification of the emotions, generally appeared to derive the supremest pleasure from the effects of alcohol. The action was really twofold, there being a diminution of inhibitory power and an increase in the more emotional or effective qualities of the brain. The frequency

of alcoholism in the neuropathic was, therefore, as much a consequence of the mental constitution as a cause of it. Experimental psychologists, by comparing the power of doing definite mental work—*e.g.*, arithmetical exercises and the like—before and after the ingestion of alcohol, had clearly proved that a lessened mental output was one of its effects. It was further shown that this action persists, and renders the effects of the second and succeeding doses of alcohol more easy of production. The speaker then referred to the desirability of a scientific commission being appointed to inquire into the whole question of alcohol. He also alluded to the very general desire on the part of the medical profession that the Legislature should assist them (as he believed could be done without undue interference with the liberty of the subject) in dealing with a class of patients who were unable to help in their own treatment.

Dr. AFFLECK spoke of the great responsibility which rested on the medical man who prescribed alcohol when it was not absolutely necessary. He thought it was often most difficult, especially for a young practitioner, to take up a definite stand. It was a drug which differed from all others, because patients often asked and expected the doctor to prescribe it. He used alcohol constantly in suitable cases, but his experience was leading him more and more to dispense with the very doses formerly used, in pneumonia, for example. As to what had been said in reference to its action in increasing the susceptibility to infectious diseases, one had only to look at pneumonia for an illustration of the fact. We all knew how grave was the prognosis in an alcoholic subject. The question was one in which he had always taken the very deepest interest, and he thought that it was futile to attempt to dissociate its medical and moral aspects.

Dr. JAMES RITCHIE alluded to insurance statistics as pointing to the evil effects of alcohol. From a large series of life-tables it was found that among the general assured the mortality was only 1½ per cent. below the expectation of life, while among teetotalers it was no less than 25 per cent. lower. Long clinical experience had convinced him that alcohol was most deleterious in many diseases. In gout he thought that medical men often shirked their duties in not enforcing total abstinence, and it was the same in some cases of chronic rheumatism. He had known many cases in which when alcohol was once absolutely stopped the gout had not again recurred. In heart disease, too, he thought that alcohol should seldom be given.

Dr. LESLIE MACKENZIE, speaking from the public health point of view, said that he could not believe that alcohol had any effect on the mortality from specific infectious diseases. In Leith there was an enormous amount of drunkenness—much more than in most other towns—yet it was notorious that its death-rate was much lower than that of any of the other large Scotch towns. Seeing that the main incidence of the ordinary infectious diseases was in children, who are naturally abstainers, he could not see that there was the slightest evidence that alcohol had any bearing on this question. The same applied to such infectious diseases as typhus, while in cholera we had a disease which occurred chiefly among an abstaining population. He then criticised adversely Dr. Arohdall Reid's theory of alcoholism, and asserted that there was no evidence of an inborn craving for the substance, or that it fills an organic want. Alcoholism was as much a consequence as a cause of poverty and vice, and formed only one part of the whole question which had to be dealt with by the social reformer rather than the sanitarian.

Dr. CHURCH thought that alcohol was of the very greatest value in acute diseases in children, but that it should be given with the finger on the pulse. If it reduced the pulse-rate and the temperature it was doing good, if not, harm.

Dr. P. A. YOUNG pointed out the enormous difference between the mortality and the morbidity of the two great friendly societies—the Rechabites and the Foresters—drawn from exactly the same class of the community, and differing only in their habits as to alcohol. The death-rate among the Foresters corresponded fairly closely with that of the general insur-

ance tables. He wished to point out that insurance companies did not accept lives in which there was a suspicion of intemperance, so that their tables of mortality gave the death-rate of moderate drinkers only, excluding those who excessed.

Dr. WELSH spoke of the diminished output of mental work following small doses of alcohol, and of its great value in certain forms of insomnia in the aged.

Dr. KEE (Superintendent of the City Hospital) said that he would not like to treat diphtheria without alcohol. Not all typhoid patients, by any means, required stimulants, but in diphtheria they were needed almost as a routine. Whenever he tried to lessen the amount of alcohol used in the diphtheria wards the percentage of cases of heart failure at once went up. The last three cases of fatal syncope in the hospital had been in patients who had seemed so slightly ill at the time of admission that stimulants were not ordered. If he was not to give alcohol, what drug was he to use? While he was waiting for strychnine or digitalis to act, the patient would be dead. In scarlet fever, alcohol was seldom needed; in typhoid and typhus he was guided by Jenner's axiom, "When in doubt, in typhus, stimulate; in typhoid, do not."

Professor Fraser and Dr. Woodhead shortly replied to the discussion.

### France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, July 7th, 1901.

#### PULMONARY AFFECTIONS.

At the Académie de Médecine M. Rendu read a paper on "Certain Pulmonary Affections Provoked by Lesions of the Nose, Ears or Pharynx." The pus from the above lesions created the pulmonary malady of which the pathogenic microbe was nothing less than that of the nasal or auricular suppuration. Frequently it was possible to trace from its origin the evolution of the malady: coryza, tonsillitis, pharyngitis, tracheitis, and finally bronchitis. The descending infection assumed varied forms, from an irritating cough to symptoms of pulmonary congestion, pneumonia, and broncho-pneumonia. Although the clinical phenomena were not exactly those of tuberculosis, confusion was not difficult; the diagnosis reposed on the presence of two facts; in the first place the existence of suppuration in the nose, ear, or frontal sinuses was noted, and generally when the patient was examined through the mouth a purulent stream was observed running down the pharynx. Secondly, the culture of that secretion and that of the bronchial expectoration furnished the same microbe, which was never that of tuberculosis. The lateral decubitus appeared to be favourable to the extension of the infection as the lung affected corresponded frequently to the side on which the patient had the habit of lying.

#### DEATH IN TYPHOID FEVER.

M. Ch. Fiessinger spoke on the cause of death in typhoid fever, and said that a fatal termination frequently occurred where the patients had not been treated by cold water. He employs either baths or the wet sheet. The baths are given at 72° F. every three hours as long as the fever attains or exceeds 102° F., and last from ten minutes to a quarter of an hour. Where the latter is not possible he employs the wet sheet. At 102° he prescribes the wet sheet spread on a blanket and wrapped around the patient for five minutes. At 103° the wrapping is repeated once again immediately, while at 104° the wet sheet is renewed three times.

The four complications which frequently cause death are intestinal hæmorrhage, perforation, cardio-pulmonary affections, and æsthenia. Frequently up to the twelfth or fifteenth day the patient is going on well, the treatment of laxatives, quinine, abundant drinks, and acidulated lotions seems to have been sufficient for a happy issue, when suddenly the fever attains 104° in the morning, the pulse becomes rapid and weak, the abdomen gets enlarged, the lungs become congested, the intellect obscured, speech difficult and indistinct, incontinence or retention of urine appears, death is at hand.

The benign form of the malady gave reason to hope that refrigeration could be dispensed with, and now it is almost too late to think of it. Let us try it, however, We need not expect anything much from other medication; injections of caffeine, camphorated oil, artificial serum, retard sometimes the fatal moment, but they hardly ever prevent it. The physician is discouraged; morning, noon, and night he injects fifteen or sixteen ounces of serum; twice or three times daily camphorated oil or caffeine, but without result; the patient sinks gradually. The only rational treatment is that of cold water, which is superior to all drugs, as it is the best agent against the typhoid poison. The wet sheet is more suitable when the fever exceeds 104°, and the prostration is great. In concluding, the speaker said that leaving out perforation, for which nothing could be done, the three other complications already mentioned could be avoided frequently by balsamation or the wet sheet. In the case of hæmorrhage, however, the cold bathing should be suspended three or four days as well as the enemata, and the accident treated with ice to the abdomen, injections of serum and the drugs usual in such cases.

### Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, July 6th, 1901.

THE *Deutsch. Med. Zeitung*, No. 50, has an article by Dr. A. Tausig on

#### TANNIGEN.

He has used it for all forms of diarrhoea, not only in children but in adults. It does not diminish the appetite, and even when used for a lengthened period it was well borne. It was specially useful in the diarrhoea of children, even in those at the breast. In diarrhoea, with an alkaline reaction, tannigen especially proved its usefulness.

The best results were obtained in sub-acute and chronic diarrhoeas of children. After the third or fourth dose even, the mucus and water in the stools diminished, and generally after three or four days the stools appeared normal.

In chronic intestinal catarrh the course was rather slower, but the effect of the drug was unmistakable. He recommends the continuance of the drug in smaller doses, even after the diarrhoea has subsided. The dose given was, in children under two, 0.25 grms.; above that age, 0.5 grms., and four or five doses daily. If it could not be given in the ordinary ways, tabloid, powder, &c., it was given in gruel. The stools were often dark coloured from its use. In acute intestinal catarrh it was not so useful so long as the acute stage lasted.

Calomel and the other older and tried remedies were best then, and later, when the stools took on the catarrhal character, tannigen soon brought about an improvement.

Simple dyspepsia and isolated stomach affections did not appear suitable for tannigen treatment.

In diarrhoea from various causes, in connection with a slight chill, measles, excitement in nervously disposed persons, in irritable bowel (nervous weakness) it always acted favourably. In diarrhoea with vomiting it almost always had a good effect. In tuberculosis of the intestines, on the other hand, any good result was only transient.

At the Society for Innere Medizin, M. Wolff showed a series of preparations of

TUBERCULOUS ANIMALS AFTER TREATMENT BY HETOL AND IGAZOL.

Both remedies named had been recommended and highly lauded as being capable of building a wall of connective tissue around tuberculous patches, and thereby bringing the disease to a standstill. The animals shown were treated simultaneously, or almost so, by inoculation of tubercle and one of the substances named. The first animal shown was a rabbit that after infection with tubercle had twenty-three injections of hetol given in the space of three months. There was still some caseation at the margin of the cornea, and the disease had also spread to the lung. Four animals were shown of the first series, and in not one had the disease been checked in the least, in fact, the animals behaved just as the control animals did that got no hetol.

Experiments on the peritoneum showed a like state of things.

Three guinea pigs inhaled tuberculous dust and became infected, two were treated with hetol and the other without. One preparation showed the lungs thickly strewn with miliary tubercle and large caseous patches. Around the patches was a distinct wall of connective tissue, but the wall in the animal not treated by hetol was quite as distinctly marked. In the third animal there was also miliary tuberculosis and extension of the disease of the liver. The disease was no worse in the control animal. He had also used it in forty-two cases of phthisis injecting it into the gluteal region. The cases were selected as being slight and free from fever. The result was very unsatisfactory, no recovery took place, the râles remained unchanged.

As regarded igazol, which was given as recommended by Cervello of Palermo, by inhalation, the result was no better. The control animal lived the longer and showed the less advanced disease than the one treated by igazol. In fact, all the igazol animals died before the control ones. In three of the animals treated by igazol, again, pneumonia was set up. It was given prophylactically to thirteen men and six women, the inhalation lasting from three to four hours daily. Of the men nine remained in the same state, three got worse, and one died. The women almost all got worse. The igazol instead of having a curative effect had rather its opposite. The speakers who took part in the discussion, among whom were v. Leyden, A. Fraenkel, and Furbinger, complimented the speaker on his experiments and acknowledged that they tallied with their own clinical observations.

Hr. v. Leyden then showed a

CASE OF RECOVERY FROM TETANUS.

The treatment consisted of serum injections. A special epoch dated from the discovery of antitoxin serum, but the results were not brilliant. The antitoxin was injected subcutaneously to neutralise the poison in the blood, but the hoped-for result did not follow, and it was then found that animals died even when the poison in the blood was neutralised. The toxin was therefore present in another part of the body, and that could only be the spinal column or the far motor ganglion cells. The spinal fluid attracted the toxin, and fluid withdrawn from a case of tetanus was able to infect mice. It was now attempted to bring the antitoxin direct into the central nervous system, and the serum was introduced below the dura of the skull. But the results were again unsatisfactory. Then Jacob evolved the idea of injecting it into the spinal canal, but experiments on animals showed nothing decisive. In a case two years ago such an injection had a good effect. Since then there had been nine cases—three recovered and six died. In the case shown the result was very satisfactory. The patient, a groom, æt. 22, was admitted on May 15th with distinct signs of tetanus. On the third day of the disease subdural injection was made of 5 ccm. of antitoxin, after 10 ccm. of spinal fluid had been drawn off. The injection was repeated three days later. The dose given now was smaller than before, Behring's original case was 2 grm. (1 grm. = 20 ccm.). The result was "éclatante." The patient's temperature fell in a few hours from 41 to 38.5, and the next day to 37.4. This effect could certainly be looked upon as life saving. Life had never before been saved when the temperature had reached 41 C. The second injection had scarcely any effect upon the temperature. The tetanic symptoms subsided slowly, but the patient was able to swallow. After such an experience this method of treatment ought to be always followed. The other and usual remedies were given when special symptoms called for them.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, July 6th, 1901.

CYLINDERURIA AND ALBUMINURIA.

KOBLEB reported some time ago that he found in the urine of patients suffering from constipation the renal elements (cylinderuria as well as albuminuria), which would continue for several days, and rapidly disappear on relieving the bowels.

To test the accuracy of this observation, Wallerstein commenced to experiment on dogs and other animals by producing constipation and closing the anal opening with similar results. After twenty-four hours' closure, in the case of the guinea-pig the examinations were carefully commenced, and on the following day distinct traces of albumen with casts. In the dogs there were no albumen, but the urine was loaded with renal casts.

On post-mortem examination of the kidneys, the microscope revealed pronounced fatty degeneration of the epithelium in the medullary substance of the organ.

BACILLI OF DYSENTERY AND DIARRHŒA.

Kruse has been devoting his attention to the bacilli of dysentery and diarrhoea with the result that he has never seen any good from serum in combating the disease

in man or animal. He confirms the number and character of bacilli present, but the sovereign remedy yet was hygienic surrounding and a heroic endeavour to reduce the flow of water into the alimentary canal. There was a sort of diarrhoea to be met with in lunatic asylums which was not to be confounded with the true septic condition, but which could not be far removed from the more virulent congener.

#### MALARIA.

Coenen has provided us with a short history of malaria as taught in Italy at the present time. In his report he commences with Virchow's discovery of pigmentary granules in the red blood corpuscles from the heart of a man who died of intermitting fever in 1848. Little was heard of the subject till Laveran discovered his parasites in 1880, which he named *Oscillaria malariae*. This idea was strongly opposed as being the true cause of malaria. In 1885 his observations were frequently confirmed. The observations of Marchiafava, Celli and Golgi all supported Laveran's theory that although the bodies were differently described by different observers it was the same in different stages of its life history.

It was left to Koch to determine that there were three different species of these parasites. 1. The quartan parasite or *plasmodium malariae*, which has a diminutive amoeboid appearance, thriving in the red blood corpuscle and destroying the pigment of the cell. After seventy-two hours the deposit is broken up into eight or twelve segments, or spores. 2. Tertian parasite or *plasmodium vivax*, requires about forty-eight hours for its development, and then it breaks up into fifteen or thirty spores, or segments. 3. The parasite of the *estivo autumnal fever*.

Manson's theory of the mosquito transmitting the poison has been confirmed by Bignami, while Battista has accused the *anopheles claviger* as the true porter.

#### NOBOSCOMIAL GANGRENE.

A literary fight has arisen between Brabec, in Maydl's clinic, and Matsenauer, of Neumann's clinic over a few particulars in nosocomial gangrene which Brabec claims to be original, while Matsenauer sets them aside as unimportant. Brabec has gone so far as to classify diphtheritic phagedænic sores on the anal and genital region as closely allied to hospital gangrene, which Matsenauer ridicules as nonsense, while Brabec insists on the correctness of his diagnosis from the confirmation rendered by bacteriological examinations.

#### THE MANAGEMENT OF CONSUMPTION HOSPITALS.

The following extracts from a letter addressed by Professor Moriz Benedikt, of the Vienna University, to Dr. Professor Allbutt, of Cambridge, and published in the last number of the *Wien. Med. Woch.*, will be read with interest in Great Britain. He says:—

"As the subject of tuberculosis will, doubtless, be taken up, after the Congress, by the English Government, and by Municipalities and philanthropists, on a grand scale, it will be very necessary to avoid serious blunders. Nowhere is philanthropy so wasteful as in England. For Heaven's sake do not build huge pretentious palaces and hospitals, like big barracks, which in time would become strongholds of *bacilli*. Every home for consumptives should be so planned that it can be demolished or burnt down without much trouble when it can no longer be kept free from infection. A hut

system is accordingly to be preferred, and the fittings must be so selected, as to material and form, that they can be effectively disinfected. The mistake generally made is to spend all the money in hand on building. One must not forget how much philanthropy has to do, in regard to tuberculosis, in looking after the family when the [bread-winner is in a home] for consumptives; and, when he leaves it, with reduced power of work and resistance, in seeing that he does not take refuge in the demon of alcohol, and ruin both himself and his family.

"Small colonies, in localities free from dust and wind, are preferable to large sanatoria. Less serious cases might, perhaps, be entrusted to families living in suitable spots, for payment, and under the superintendence of doctors, as the danger of infection from single patients is not considerable."

## The Operating Theatres.

### CANCER HOSPITAL.

ABDOMINAL HYSTERECTOMY. — MR. CHAS. RYALL operated on a woman, *æt.* 35, who had been admitted for menorrhagia. About six months before, the periods first became profuse, and had steadily got more so, now lasting ten to fourteen days, with the passage of large clots, this having adduced profound *anæmia* in the patient. There was no great pain, no marked loss of flesh, and no interference with micturition, but there was obstinate constipation. On examination a tumour of the uterus was found filling the pelvis and extending about two fingers' breadth above the pubes. The os uteri was patulous and the length of the fundus considerably increased. A soft myoma of the uterus was diagnosed, and as palliative measures had previously been tried without any relief hysterectomy was recommended. Under ether a medium incision was made, and by the aid of a myoma screw the uterus with the tumour was drawn out of the wound; the vessels of the broad ligaments were temporarily secured with forceps, and the uterus was amputated about the level of the internal os, the vessels of the broad ligament were now permanently secured with silky ligatures, and the peritoneum was sewn over the cervical stump. The abdominal wall was closed in three layers. Mr. Ryall said that the tumour consisted of a soft single myoma growing from the posterior wall of the uterus, externally it was covered by peritoneum and internally by the endometrium. This type of tumours, he pointed out, was of a much more serious nature than the hard multiple fibroid, as it usually tends to gradually increase in size and was also associated with profuse menorrhagia which, after a time, might even threaten the patient's life, therefore he considered it was one of those cases where the surgeon had little hesitation in operating. Of all fibroid tumours he thought it was the one in which surgical treatment was most indicated. He also added that no new method was adopted in the technique of the operation. These kind of cases, he said, generally do very well. Occasionally, however, patients have afterwards a persistent vaginal discharge, owing to infection of the ligatures; the discharge finding its way through the cervical canal; this discharge, however, will cease when the offending ligature comes away, or is removed per vaginam. This *contretemps* (the vaginal discharge), he remarked, only occurred in a very small percentage of cases.

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**The Medical Press and Circular.**

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, JULY 10, 1901.

**THE HEAT WAVE IN NEW YORK.**

FROM America, a country that deals habitually in large figures, has recently come the news of a vast calamity that has swept the country in the shape of a heat wave. New York has been devastated by the advent of this unwelcome climatic scourge, and for a week or more has been paying on that score a death-toll to the extent of hundreds of dead and disabled in a single day. The official report for July 4th showed 190 deaths and 300 cases of prostration from heat, a number which we are assured is small when compared with the returns of the preceding day. Nor is the immediate outlook reassuring, for the Government weather expert says that although there has been a slight remission there are as yet no signs of permanent improvement. The area involved appears to comprise more or less completely the northern States east of the Rocky Mountains. Naturally the occurrence of so great a disaster in America is calculated to cause some uneasiness in Transatlantic countries, inasmuch as it has long been recognised that some of them, notably the United Kingdom, have in many if not most cases an unwelcome reversion of the meteorological extremes experienced in the United States. For a long time past British Army surgeons have been familiar with the disease among our troops serving in tropical and sub-tropical climates. Curiously enough, in spite of the great strides of scientific medicine, especially in the field of tropical diseases, the ætiology of "sunstroke" still remains obscure. Excluding the apyretic cases, the name of "thermic fever," or "siriassis," is usually applied to the far commoner form, in which an early symptom is a sudden rise of temperature which mounts to 105° F., 110° F., or even higher. The more marked features of the attack are headache, loss of consciousness, vomiting, and shock, and ending either in death from asphyxia or heart failure, or

in recovery with tendency to relapse and many sequela. The theory of causation hitherto most commonly accepted has been the somewhat vague statement that the extreme heat has disturbed the temperature-controlling centres in the brain and the spinal cord. The pyrexial cases, however, have lately been regarded by some observers as due to specific invasion, upon such grounds as their suddenness of onset, their marked peculiarities of type, and the tolerance or immunity as regards them found among natives and old residents. So eminent an authority as Dr. Sambon does not hesitate to include thermic fever among the infectious fevers. He has pointed out that the distribution of the malady is practically restricted to low-lying districts, and that it is never met with much above an altitude of 600 feet. This standpoint boldly places siriassis among endemic diseases; and extreme solar heat must according to that view be considered as a necessary concomitant in its production. In other words, while heat is a necessary contributory factor the actual source of the malady must be sought in other directions. It will undoubtedly occur to many of our readers with regard to Dr. Sambon's observations that New York is built on low-lying, swampy ground. Fortunately, while the exact pathology of heat apoplexy is still uncertain, a considerable advance has, nevertheless, been made in practical treatment of the condition. One of the most powerful remedies is cold, applied in various forms, together with prompt and continued stimulation in order to combat the ever present danger of heart failure. Under the best methods, however, the case mortality among British troops in India is stated by Dr. Manton to be one in four. By way of prevention it is important to adopt light clothing, to avoid alcohol, to refrain as far as may be from any mental or bodily strain, to live simply, and to keep out of the sun as far as possible. Meanwhile, it is earnestly to be hoped that the heat wave will not reach our shores.

**THE SURGERY OF UTERINE PROLAPSE.**

ONE of the first problems to attract the attention of the new school of gynecologists was the means of affording permanent relief to that distressing condition, prolapse of the uterus. The etiology of this affection is not as clear as one could wish. It is ascribed to stretching or relaxation (?) of the ligaments supporting the uterus from above and, incidentally, to rupture of the perineum, although the latter lesion cannot play a very important part in its production, seeing that a remedial operation for the latter does not necessarily effect a cure of the former. It is said to occur in women of lax fibre, but this is a vague expression which does not convey any very definite idea. Clinically, however, prolapse of the uterus is very frequently met with, and is productive of considerable discomfort even in the mild form in which the organ does not pass beyond the vulva. In its severer forms it is an evil not to be borne, and it



seriously handicaps women who are dependent upon their exertions for a living, or who have household duties to perform. It is of course only in the severer forms that surgical intervention is likely to commend itself for adoption. The lesser degrees can usually be kept within reasonable limits, at any rate for a time, by means of a suitable pessary, although we have to consider not only the discomfort which the wearing of a pessary sufficiently large to keep in place entails, but also the fact that sooner or later the dilating pressure which it exerts on the walls of the vagina reduces its supporting powers. In devising a means of affording efficient support to the uterus, we have to bear in mind that we are not dealing with an organ like the kidney which is always, roughly speaking, of the same size. We have to allow for pregnancy, and moreover care must be taken not to leave the parts in a state which might favour strangulation. Of course all suspensions of the uterus of whatever kind are to some extent mere makeshifts, but anchorage of the organ by means of the round ligaments is the nearest approach to the ideal, and as a choice between evils the round ligament suspension is superior to all others both from a physiological and from a practical point of view. The operation devised by Alexander and modified by Kellog is perhaps the most useful, though it is sharply criticised on both sides of the Atlantic. It is a somewhat difficult operation requiring, like most of the abdominal operations, skill and training for its successful execution, but the principal drawback seems to be the difficulty of finding the ligaments. The Kelly operation, it is urged, often leads to serious embarrassment in pregnancy and may even offer insuperable obstacles to parturition, so that it is only suitable as a post-climacteric operation, or in the case of women who have been rendered sterile by removal of the uterine appendages. At present we have virtually no choice between these operations and leaving matters much as they are. What surgeons must aim at is an operation which will utilise the natural supports of the uterus, will ensure a certain amount of mobility, will adapt itself to the functions of the uterus, will be lasting in its results, and will be reasonably easy of execution. Various operations have been proposed, for which it is claimed that they fulfil these desiderata, but the results obtained by surgeons who follow the directions of the inventor do not tally with those on which the claim is based, so that we may take it there is still room for further modifications in the technique of this operation before it can be confidently recommended for general adoption.

#### RAILWAY HYGIENE.

THE number of railway passengers has increased from 73,000,000 in 1850 to 1,107,000,000 in 1900. Until a few years ago the different railway companies seemed quite indifferent to the hygienic condition of the vehicles they provided for the public. In some few instances passengers who suffered from the effects of long retention of urine and so forth obtained good

damages, and it was found to be in the interests of the shareholders to provide proper lavatory accommodation. Competition was also a factor in producing more roomy carriages, better ventilation, an improved system of warming the coaches, and seats framed more for comfort than torture, which seemed the former rule. Thus the more glaring defects were got rid of, and it became possible to travel third-class in comparative comfort. But even now railway travelling implies many risks from the unhygienic conditions of many of the carriages of every class. The loathsome and dangerous habit of spitting on the floor of carriages is still practised, and in the evening of the day many third-class carriages become filthy from the habit. There is no systematic cleansing of the floor of such carriages on the completion of each journey as there should be. If the habit of spitting in trains cannot be put down suitable spittoons should be provided. We think that in all trains a special carriage should be provided for invalids; at present the wealthy invalid traveller may experience little inconvenience on his journey, but it should be possible for the man of limited means to secure a couch, or bed, and some little extra attention on his journey. Railways are our common means of transit, the great powers conferred on the companies have practically placed the travelling public at their mercy, and companies ought to remember that they have their duties as well as their rights. But over and above all these details reform is required, especially in saloon and first-class carriages, of which the thick carpets, brushed daily, impregnate the cloth-covered cushions, the depressions made by the buttons, the crevices between the seat cushion and the back cushion with all manner of foulness carried on the feet of travellers from the streets and platforms. A quick, sharp brush, which is all they get from the whisk of the railway porter, simply displaces a little cloud of dust from one corner to another. There should be no fixed cushions or nailed-on covers in railway carriages—regard for public health forbids it. All the furniture and fittings of a railway carriage should be removed at the end of each journey and disinfected and the carriage thoroughly cleansed before being sent on another journey. Objection may be taken to the cost of such measures for preserving the health of the travelling public; but we think that they are fully justified by the fact that many millions of the public make use of the railway, and their lives are quite as precious as those of oxen, and we need not remind our readers that after every journey a cattle waggon must be cleansed and thoroughly disinfected.

#### Notes on Current Topics.

##### The National Hospital for the Paralysed and Epileptic.

THE report of the Committee of Inquiry appointed to investigate the affairs of the National Hospital for the Paralysed and Epileptic was adopted by the

governors and subscribers of that institution on Saturday last. The effect of this is to put two members of the medical staff on the Board of Management, to abolish the office of Secretary-Director, and to provide for the revision of the rules. During the course of this controversy, we have from time to time warned the Board of Management what the result must be of treating eminent medical men on their staff "as if they were porters," a term, it will be remembered, actually applied to the members of their medical staff by that body. The Board have received their just punishment in the report of the Committee of Inquiry, and to resign appears to be the only dignified course left to them to pursue. In addition to having to listen to some stinging remarks from Mr. Melvill Green, the Board received a most severe and just rebuke from the medical staff, for which they had only themselves to thank. The chairman actually declared that the medical staff had never informed the Board of the more serious defects dealt with in the report, a particularly foolish statement to advance, because the report actually blames the Board for intimating to the medical staff that they were not to report defects to them, but to the Secretary-Director, and to him only. The spokesman of the medical staff in this matter was Mr. Horsley, and all that the Chairman of the Board could find to say in mitigation, after having to submit to the justly severe censure administered, was a meek appeal that he hoped he would not be thought to have been disingenuous. A strong committee has been formed to reorganise the hospital, and with a prospect of proper government an even larger measure of success than it has already secured can be confidently anticipated for this excellent charity.

#### Cæsarean Section.

THE advance of medical science has enabled the practitioner of to-day to discuss with no uncertain mind the propriety and safety of delivering by Cæsarean section a woman at term who wishes for a living child, but on whom the induction of early labour at the proper time has not for some reason been practised, and in whom the pelvis is too small to allow a living child to pass at term. It is certainly a sign of the modern trend of thought that Professor Sinclair, of Manchester, should have chosen the present time for delivering "A Plea for Cæsarean Section" at the London Polyclinic, on June 26th. Very notable attention was paid by the audience to the lecturer's description of his last case of Cæsarean section, which, he stated, was the first operation of the kind that had been done without a general anæsthetic since the introduction of chloroform, local anæsthesia being procured by the injection of solution of cocaine. It took only five minutes for the patient to become absolutely anæsthetised from the waist downwards. She was blindfolded and cotton-wool put into her ears so as to avoid anything being seen or heard by her to

cause shock, and a nurse stood by her side to comfort her during the progress of the operation. The patient complained of no pain and simply asked for a drink. The reason for employing cocaine in this case was because the patient had a dilated heart, and had been the subject of bronchitis for many winters previously. It is possible that the place of chloroform may be taken by this method of injecting cocaine to secure local anæsthesia, and this particular woman, whose case was commented on by Professor Sinclair, did very well and made an excellent recovery despite the fact that she was a somewhat elderly primipara, aged 39. It must be admitted that one of the causes of fatal endings in the operation for Cæsarean section is the injudicious interference previous to the operation, and also, to quote Professor Sinclair again, the want of a fixed resolution as to a definite and distinct line of action and early diagnosis of the condition. After this early diagnosis there should be prompt and decided action. The most hazardous course that can be followed in these cases is to finally resort to Cæsarean section after futile delay and objectless shilly-shallying, taking up one plan only to give it up for another, and generally exhausting the vitality of the patient.

#### The Midwives Bill.

By the permission of the Lady Balfour of Burleigh, the Association for Promoting Compulsory Registration of Midwives held a meeting in her drawing room at 47, Cadogan Square, on June 28th, to receive the annual report and to generally help forward the Bill that the Association so nearly managed to pass through the House of Commons. Lord Balfour of Burleigh comforted the members for the disappointment in the failure of the Bill to get through by assuring them of his warm sympathy with their efforts, and this friendly disposition on the part of a member of the Government was, as Mr. Crombie, M.P., pointed out, a matter for sincere congratulation from the point of view of the members of the Association. Members are to be induced to ballot for the Bill next Session, and the Government is to be shown that legislation must be obtained by means of private members and their constituents being persuaded to show great determination in pushing the Bill. Working-class mothers are to be addressed all over the country warning them of the risks they run in employing ignorant midwives. The support of the mothers is to be enlisted, and especially that of their husbands, who can vote, as the people most vitally concerned in the movement of the Association. The whole country is to be mapped out, and societies formed to appeal directly to the people and to rouse that public opinion without which Parliament will not move. A plea not unusual under similar circumstances is made for money, and the Association trusts that there will be no falling off in the donations. Great hopefulness was evidently aroused by the statement in the report that in the

opinion of Dr. Percy Boulton and Dr. Champneys medical opposition to the Midwives' Bill is largely diminishing. The Association consider that steady progress has been made in spreading a knowledge for the need of the legislation they propose, and that every year shows a more widespread conviction among the public that the present state of things cannot be allowed to continue.

#### Spinal Anæsthesia by Cataphoresis.

THE risk attendant on opening the dura mater of the spinal cord has, perhaps more than anything else, done much to make unpopular anæsthesia by the ordinary method of injecting the cord with cocaine. Injection of the fluid between the arachnoid membrane and the dura mater has, as has been noted in THE MEDICAL PRESS AND CIRCULAR, been recommended and tried, but it requires great dexterity to just penetrate the dura mater only, and there is always the doubt as to the success of the operation. To avoid the risk of the earlier operation and to get rid of all doubts as to the successful performance of the second, Dr. Leonard Corwing has proposed that cataphoresis be utilised to make the anæsthetic penetrate the spinal membranes. The method has been successfully tested, by its author, on a patient in a New York hospital, who underwent an osteotomy of the foot. The anæsthesia was so long in coming on, full half-an-hour, that ether inhalation was resorted to, but scarcely were the preliminary steps of the operation taken than the house surgeon drew attention to the fact that the patient, now entirely conscious, for the ether inhalation had been discontinued, was suffering no pain. From then on there was no giving of ether whatever, the patient conversing with those about him quite contentedly, and without the least sign of discomfort, "although cutting, chiselling, sawing, and suturing were indulged in, according to the technical demands of the occasion." (*New York Med. Jour.*) The steps of the operation differ considerably from any of those formerly proposed, in that the author makes an incision between the spinous processes of the fourth and fifth lumbar vertebræ, a little to the right of the ligamentum interspinosum, thrusting the knife down to the ligamentum subflavum. This being done he penetrates the ligament with a fine telescopic-like tube, which fits accurately the outer tube which rests on the ligamentum subflavum. The fine inner tube projects half-a-centimetre beyond the outer tube, and is rounded at its extremity, and is deficient in the sharpness necessary to penetrate the dura mater. Having pierced the ligaments a syringe is attached to the smaller tube by means of a socket, and the anæsthetic fluid is injected in the dura mater. The syringe and the smaller tube are now removed, and the positive pole of a galvanic battery is secured to the outer tube, and the negative sponge of the battery is placed on the abdomen; and the current turned on until the milliamperemeter showed three-tenths of a milliamperemeter. Should any doubt arise as to the perforation

of the dura mater by the inner tube the piston of the hypodermic syringe can be withdrawn, and if no spinal fluid is found the membrane is intact.

#### Important Legal Decision on the Sale of Food.

THE very important issue raised in the case of Wallis against Russel, commonly known as the "Cork Crab Case," has been decided, on appeal, in the King's Bench Division, by the Lord Chief Baron and Mr. Justice Andrews. To the medical profession the decision is of much importance, as it is distinctly and rightly based on the *caveat emptor* principle; any other principle would wreck the beneficent design of all the recent legislation passed for the protection of the buyer of food. The plain intent of buying food is to prepare it for human use, and the essential condition of sale is that the food is fit for human use. It was argued that crabs were natural products, not manufactured ones, and that they were sold as such without warranty. But as the Lord Chief Baron pointed out that the Act applied to goods of a description which it was in the course of a seller's business to supply, and that liability was to attach to the dealer as such. The case is one of great simplicity although it raised such important legal issues. The plaintiff bought of the defendant, who is a fishmonger, some crabs which were dressed and eaten by his wife and family. During the night marked toxic symptoms in all who ate of them were found, and their lives were saved with much difficulty, convalescence being long and staggering. Toxic effects from shellfish are not unusual; they may result from idiosyncrasy, from improper feeding of the crustaceans, or from the natural process of decay in fish kept too long. In this case there was, however, no question as to the freshness of the crabs. Idiosyncrasy was not considered, so we may suppose that there was none; but remains the question as to the site of the fishing grounds for the crustaceans. If the fish fed in a sewage impregnated district we might reasonably conclude that others would have suffered similarly to the plaintiff and his family; but there is no such account. We are told nothing of how the fish were cooked, or what, if any, drink was taken with them. The case has, however, definitely settled an important legal point that affects every member of the community, by establishing a principle that, though it may at times press hardly on vendors, is a protection to the public and a safeguard to public health.

#### Plague and Small-pox in Glasgow.

THE annual Congress of the Sanitary Inspectors of Scotland at Glasgow has naturally given rise to retrospects of the plague and pestilence to which the ancient town has of late been subjected. Lord Provost Chisholm very naturally congratulated his townfolk on the way in which bubonic plague had been stamped out of their midst, and the disease prevented from extending to other parts of Scotland.

At the same time he was obliged to admit that there were many unsanitary areas in the city that formed fit nursing places for infectious disease. That fact was illustrated by the recent epidemic of small-pox that had swept over them, but now, happily, had been banished. The experiences of that outbreak had left him more than ever a firm believer in the virtues of vaccination, but the public must not be permitted to imagine that universal vaccination would be any excuse for lax sanitary administration. With regard to the recent critical experiences of Glasgow, it may, perhaps, be permitted to remark that a Corporation which has sent plague so promptly to the right-about should surely be able to deal effectually with the less deadly home infections, such as small-pox and scarlet fever. But how, above all things, can so enlightened and progressive a municipal government permit the Clyde to remain the most offensive ink-black river of foul pollution known to the civilised world? What has the Lord Provost to say upon that point?

#### Chorea and Rheumatism.

"CHOREA is rheumatism of the brain, and I feel as certain of that as I do of anything in medicine." These are the words used by Sir Dyce Duckworth in addressing his students at St. Bartholomew's Hospital a short time since, and in support of his view he was able to add that the recent researches of Drs. Poynton and Payne have rendered his conception as nearly certain and positive by way of demonstration as anything can well be. These two observers have succeeded in inducing chorea in the rabbit by the inoculation of the diplococci of rheumatism, and they have detected these diplococci in the endothelial cells and capillaries of the brain. They found them not only there, but dipping into the motor centres of the rabbit's brain. That is almost as complete and perfect a demonstration of the nature of the disease as could be wished for, but Sir Dyce Duckworth was singularly fortunate in being able to quote an extremely interesting case of fatal chorea in the human subject, in which Drs. Poynton and Payne discovered these rheumatic organisms in the mitral valve and also in the motor cortex of the brain. The very natural conclusion these gentlemen have drawn is that chorea is induced by the presence of these diplococci or of the toxins which they produce in the brain. It would be difficult to describe the modern view of the morbid anatomy of chorea more concisely and clearly than Sir Dyce Duckworth, who says that so far as it has been studied it shows nothing incompatible with the theory that it is an inflammatory process depending on microbic invasion, and the symptoms of the disease appear to indicate that the changes are caused by multiple local lesions due to the deposition of a particular form of disease rather than to any diffuse toxæmia. Believing that the determination of this process to the brain will only occur in persons particularly and specifically predisposed to brain weak-

ness, we naturally come to regard it as rheumatism localised in that organ.

#### Foreign Students in Germany.

NO better testimony could be forthcoming of the high esteem in which German methods of teaching are held by the world at large than the very large number of foreigners who avail themselves of the facilities provided by the various universities. Apart from the Russian students, who, for political reasons, prefer German schools to their own, close upon two thousand other students of all nationalities rub shoulders with the native students. In view of the fact that the foreign students pay for their education on the same footing as the native contingent, one would have thought that both professors and the general body of students would have been flattered and pleased at this evidence of popularity. Apparently this is not the case, for a movement of protest against the large admixture of foreign students has been inaugurated, on the ground that the native students are crowded out. This is a very good reason for requesting the authorities to provide additional accommodation, but certainly not for proposing the exclusion of foreigners. We should be sorry to see German universities follow the example of the French in placing obstacles in the way of foreigners desirous of availing themselves of their educational institutions. In years gone by it was the boast of the French school that it was the favourite resort of the studious youths from all parts of the world, a proud position which a narrow-minded protectionism has ruined, although to its popularity with foreigners the intellectual pre-eminence which France formerly occupied in Europe, and indeed in the world, was largely due. Let our German scholars remember that science knows no frontier, and that it is a privilege to be jealously safeguarded to be able to attract and retain the affection of the studiously inclined.

#### Velociphilia.

THE disease which a French author has described under the name velociphilia is not a new one, though it has of late assumed an epidemic form. It was a mild and comparatively inoffensive affection so long as it could only be indulged in by those who were willing to use their legs for the purpose of rapid progression. It occasionally assumed an acute form in equestrians who risked life and limb in their endeavour to outrun the hounds; but it was not until the advent of the modern bicycle that it attained such dimensions as to constitute a peril for the public and a source of evil for the victims. Within the last few years the perfection attained by the motor car has been the means of developing the malady in a form dangerous at once to the public and to its victims. In years to come it may be that our faculties of direction and our agility may adapt themselves to new and altered requirements, but at present the motor car is an unmitigated terror to those whose nerves are ever being agitated by the peremptory

hoot. It is idle to look to repressive penalties to stem the course of the epidemic. Under the empire of this emotional mania the otherwise sane man rushes headlong to his doom, oblivious alike of the risks which beset him as he careers along the dusty road at express train speed, and of the dangers which his rapid passage entails on other travellers. The only effectual safeguard would be to refuse the liberty of the streets and roads to all cars not provided with a permit of circulation, such permit only being accorded on its being shown that the mechanism does not admit of a speed greater than that allowed by the traffic regulations. We do not attach much importance to the proposal to make these cars carry numbers. Enveloped in a cloud of dust, the outraged pedestrian would not be in a favourable position to distinguish the number of his assailant, which, moreover, it would be easy enough to mask at critical moments.

#### The Royal College of Surgeons of England.

THE ballot for the election of three members of the Council of the Royal College of Surgeons of England took place on July 4th, with the following results:—Mr. Arthur William Mayo Robson, 332 votes; Mr. William Watson Cheyne, 302; Mr. Richard Clement Lucas, 259. Of the unsuccessful candidates, Mr. John Hammond Morgan obtained 236 votes; Mr. Charles William Mansell Moullin, 235; Mr. Henry Hugh Clutton, 145; Mr. John Bland-Sutton, 193; and Mr. Jordan Lloyd, 93. Seven hundred and fifty Fellows voted by paper and eighteen in person. Mr. Mayo Robson and Mr. Watson Cheyne were declared to have been duly re-elected, and Mr. R. C. Lucas duly elected.

#### Indian Army Medical Reform.

SOME of the service journals are turning their attention to defects in the Indian Medical Department. On the principle that coming events cast their shadows before them, it is to be hoped that these editorial straws point to the setting in of a strong reforming current in that direction. From a scientific point of view the present system may be regarded as absolutely throttling to all individuality and its resulting efficiency. The test of a man's opinion appears to be his status in the army, a sacrosanct qualification quite apart from such lay trivialities as his scientific attainments. If we judge the tree by its fruits then the army medical service in India stands self-condemned. After generations of official administration the death-rate from cholera and enteric fever remains very much as it was, notwithstanding the vast scientific advances that preventive medicine has made in dealing with these scourges of mankind. Surely any service with a real grip of the situation would have long ago placed its standing camps and barracks on a sound sanitary footing. So far from that the average view of the Indian Army surgeon upon sanitary matters appears to belong to a fossil and pre-scientific age. Even now the essentially water-borne nature of cholera and enteric fever is not generally

recognised, or, at any rate, if recognised, is not reduced to a practical sanitary basis. The death-roll from preventible diseases among British troops in India is a standing reproach to our medical administration in that Empire. It is a significant fact, moreover, that few, if any, of the great advances in tropical medicine have hailed from India, in spite of the enormously wide field thrown open to scientific investigation.

#### The Congress of Tuberculosis.

THE arrangements for the approaching Congress, which is to be opened by the Duke of Cambridge on the 22nd inst., are now virtually complete, and there is every reason to anticipate a successful meeting. There is a veritable plethora of contributions, many of which will necessarily have to be "taken as read" in order to leave time for the discussion on the more important. It is hardly to be expected that anything strikingly new will issue from the debates. The object of these congresses is to educate the profession and the public by generalising the knowledge we already possess in regard to the etiology and spread of this fell disease, more particularly from the preventive aspect. We have as yet only touched the fringe of the subject, and as legislation cannot usefully go in advance of public opinion, it is all important to seize every opportunity of familiarising the public with the steps that have been taken and suggested with this object in view. It will greatly facilitate matters if those who intend taking part in the Congress will lose no time in inscribing their names at the headquarters, 20, Hanover Square.

#### The Reform of the Army Medical Department.

THE latest information vouchsafed in regard to the Committee of Experts renders it more than ever necessary to suspend judgment. It appears from a reply by Mr. Brodrick, in parliament, that the Committee will not take evidence, and that its proceedings will be private, though it will (of course) be open to any member of the Committee to submit alternative proposals. The least reassuring item of the reply was that which dealt with the scope of the reference which, it seems, is not to be made public. For the present, therefore, we must await the result of the Committee's deliberations. Meanwhile the competitive examinations have been suspended owing, it is asserted, to the lack of candidates.

#### An Unregistered Resident Medical Officer.

AT an inquest held last week at the Clayton Hospital, at Wakefield, Mr. George Robert Butler, M.R.C.S., who is acting as locum tenens for the assistant house surgeon, was a witness, and it transpired that his name did not appear on the *Medical Register*. The omission was explained on the ground that the last issue of the *Register* had been "newly printed," which we take to mean that this gentleman had omitted to make known his change of address, his name having been deleted in consequence. In consequence of the more stringent rules which have

come into force with respect to identification, there was, he stated, difficulty in the way of his getting the omission remedied until such time as he could go to London for the purpose. The Coroner pointed out that the witness was liable to a penalty, which the latter denied. Technically the Coroner was probably in the right, and in any event we trust this case will impress upon all duly qualified practitioners the propriety of taking care that their registration does not lapse

#### Bathing Fatalities.

THE advent of the summer season has been ushered in with even more than the usual list of bathing fatalities. Of such accidents there can be no doubt that a great many are preventable, that is to say, they should not occur under conditions of ordinary prudence. The number of persons who are drowned every year because they cannot swim is simply appalling. With regard to swimming it need hardly be remarked that in addition to being a most desirable acquirement it is a delightful and health-giving exercise, which brings grace and vigour to the body. To swim, however, especially in rough water is an extremely athletic exercise, and cannot be undertaken lightly by any person who is not more or less in that state of bodily fitness known as "training." The majority of bathing accidents probably happen to those who overtax their muscular resources too suddenly and too severely directly they get down to the seaside. Another risk arises from too frequent bathing. Only a few days ago an inquest was held on an ex-champion diver and swimmer who had tempted fate by swimming in the Thames several times in a single day. The fact is that those who contemplate seaside or inland bathing would do well to consult their medical attendant beforehand upon the matter. Many a man and woman with weak heart and feeble circulation, or with flabby muscles would thereby be warned against incurring unnecessary dangers. This sort of warning cannot be picked up from books, but may always be obtained from the ripe treasury of sagacity that is gathered by the practitioner from the broad harvest fields of medical practice.

#### The Spinal Symptoms of Tea Intoxication.

THE injurious effects of excessive indulgence in tea on the digestion and on the nervous system are familiar to most practitioners in this country, where tea inebriety is probably more frequent than elsewhere. It is doubtful, indeed, whether practitioners generally recognise to the full what a potent agent for evil tea-drinking may prove, especially when, as is so often the case, it is associated with inadequate nutrition. At a recent meeting of the Neurological Society of Philadelphia, Dr. Alfred Gordon showed some patients who presented certain well-defined spinal symptoms dependent apparently upon chronic tea intoxication. From ten to fifteen cups of tea daily had determined unsteadiness of gait and easily induced motor fatigue. The knee jerks were increased, sensation was impaired in some regions and enhanced in others. The pupils were unequal and

there was nystagmus. It is open to question whether these spinal symptoms were due exclusively to the tea or to the ingestion of minute quantities of lead therewith, but the communication suggests a useful field for future study.

#### Degrees for London Diplomates.

THE diplomates of the London Royal Colleges are still restlessly agitating for facilities at the hands of the reconstituted University of London in the direction of obtaining a medical degree, but so far there is no sign that their not unreasonable demand is likely to meet with a favourable reception at the hands of the authorities. There is no obvious reason why special facilities should not be offered to diplomates willing to comply with reasonable requirements in order to acquire the coveted degree. In future, no doubt, most metropolitan students will take care, when they enter on the study of medicine, to keep in touch with the University; but this leaves a very deserving category of qualified men out in the cold. The best course for them to adopt would be to formulate a tangible proposal which could be urged on the attention of the Senate for approval. It is useless to cry in the wilderness, leaving it to others to state exactly what they want.

#### Buxton Spa.

THE historical virtues of Buxton water are historical. So long ago as the Roman era it was devoted to the uses of Æsculapius. Since then it has always been a resort for invalids, and numerous references are to be found from time to time in the pages of English history. There is no need to refer to the fact that the mineral springs which have made Buxton famous are chiefly chalybeate and calcareous, the latter both hot and cold. In addition to the waters, however, visitors have the benefit of a glorious mountain and moorland scenery, which of its kind is perhaps the most compact and beautiful in all England. Indeed, it would be hard to imagine a more complete and restful change for the jaded town dweller than the clear and bracing atmosphere of Buxton. During the last two generations great changes have been effected in the town, whereby it has become one of the most perfectly appointed of spas. The Devonshire family, who for centuries past have practically ruled the country round, have taken the lead in these improvements. One of their greatest public benefactions has been the Devonshire Hospital, which for forty-two years has fulfilled a career of unbroken usefulness and success. During that period no less than 82,000 gouty and rheumatic patients have passed under treatment, and of that number it is reported that no less than 74,000 have received lasting benefit. It would be superfluous to comment upon a record of that kind, which speaks for itself with absolute emphasis, and bears eloquent testimony to the causes that have given Buxton a foremost place among English spas.

### The Toxæmia of Burns.

In those cases where death has occurred from the effects of severe burns evidence is not unfrequently found, on post-mortem examination, of ulceration of the duodenum. The theory for some time was that this lesion might be due to capillary embolism consequent upon the presence of disintegrated blood in the vessels. In connection with this point there was read, at the Association of American Physicians, a suggestive contribution by Dr. McCrae, of Montreal, entitled "A Study of a Series of Cases of Burns," in which the author puts forward the theory that the mischief may be due to a toxæmia similar to that produced by bacteria. The pathological processes at any rate present a striking similarity to those met with in diseases characterised by the presence of toxins in the blood. The investigations of Bardeen were suggested by the similarity of the lesions found after burns and those accompanying diphtheria, in fact the changes in burns are more proliferative than degenerative. One view, probably the least open to objection, is that the toxin elaborated in a burn is due to the action of heat on the blood in the superficial capillaries. The subject is one which, of course, has received the closest attention of skilled observers, but so far without clearing up the pathology of this very curious and interesting lesion.

#### PERSONAL.

LIEUT.-COLONEL R. W. BARNES, Royal Army Medical Corps, retired, has been granted the local rank of Colonel whilst in charge of a General Hospital in South Africa.

DR. J. W. WASHBOURN, Assistant Physician to Guy's Hospital, who went to South Africa with the Imperial Yeomanry Hospital in February, 1900, has returned to London.

MR. J. H. LITTLEJOHN, who for nearly six years has been Medical Officer of Health for Scarborough, has been appointed to a similar position at Hampstead, Middlesex, at a commencing salary of £600 per annum.

THE Gold Medal of the Royal Navy Medical Service for the year has been awarded to Surgeon A. J. Wernet.

THE John Malet Purser Medal has been awarded to Mr. Reginald H. Lee by the Council of Dublin University Medical School.

DR. J. LOBBAIN SMITH has been appointed a member of the Commission "to inquire into the present condition of the higher, general, and technical education available in Ireland outside Trinity College, Dublin, and to report as to what reforms, if any, are necessary in order to render that education adequate to the needs of the Irish people."

DR. ROBERT W. DOYNE, of Connaught Square, W., and Oxford, had an unique experience a few days since. He found himself in a carriage on the 1.13 express from Oxford alone with a man, and on awakening from a doze he noticed blood on his fellow traveller's boots. On examining him more closely he saw that he had cut his throat and was covered with blood, facts to which he subsequently testified at the inquest.

### Edinburgh.

[FROM OUR OWN CORRESPONDENT.]

#### THE LATE PROFESSOR TAIT.

PETER GUTHRIE TAIT, D.Sc., F.R.S Ed., &c., the celebrated exponent of natural philosophy in the University of Edinburgh, the one time Senior Wrangler of Cambridge, and prizeman in several other cognate matters at or about the same time, the collaborator with Lord Kelvin in various standard works on physics, died last week at the residence of his old friend and scientific colleague, Sir John Murray, in the suburb of Edinburgh known as Trinity, which lies by the sea-shore. A worthy successor to Hamilton and other celebrated occupants of the Edinburgh Chair of Natural Philosophy; a man of unusual mathematical talent, to whom intricate physical problems, comprehensible by but few others, were a joy, a pleasant amusement; a man wholly devoted to his life's work, to the exclusion of almost all else; he, nevertheless, possessed the gift of lucid explanation, the rare endowment of perfect adaptation in word and line of thought to the capacity of his hearers, and, another characteristic, by no means common, the possession of a fund of dry Caledonian humour.

Disdaining to be the slave of sartorial fashions, seldom seen in other than a grey tweed suit of a very personal cut, and a soft hat, he was in private the most genial and, at the same time the most rationally unconventional of men; one of the most interesting of conversationalists, ever disclosing, directly or indirectly, the fact that the working of his mind was chiefly influenced by his predominant characteristic—arithmetical and propositional.

Although he was not actually a member of the medical profession, he was directly associated with medicine in connection with the teaching of physics to medical students in their first year.

The conjoint works of Professor Tait and Lord Kelvin illustrate in a marked manner the extraordinary power of invention and theory of the latter; the striking faculty of the former for practical exposition and lucid description.

Tait, now and then, strayed from the strait and narrow path of higher mathematics; he investigated the flight of golf-balls, drew up formulæ to represent the characteristic course traversed by a child's indiarubber balloon when propelled through the air by a sharp blow.

For many years Professor Tait had filled the post of Secretary to the Royal Society of Edinburgh. Indeed, his devotion to this Society was almost Quixotic, as for its sake he resolutely declined to seek the higher honour of F.R.S.

Professor Tait's illness began last year, shortly after the death of his son, Lieutenant Freddie Tait—as well known for his physical achievements in golf as his father for his philosophical achievements in physics—killed in South Africa; caused him to resign all official posts some months ago, and at a time when a greater hope that his life, with that power of adding to the world's store of knowledge, the perquisite of his brain alone, might be prolonged to man's advantage, the sudden onset of hæmorrhage—the source of which has not as yet been indicated, although maybe aneurysmal—rapidly closed a life of unbroken application and of unquestionable benefit to mankind.

### Glasgow.

[FROM OUR OWN CORRESPONDENT.]

ROYAL INFIRMARY RECONSTRUCTION SCHEME.—This subject is exciting considerable attention in Glasgow, and calling forth much adverse criticism. Following the letter of Dr. R. Anderson, architect, to the newspapers, complaining of the shabby way he had been treated as assessor by the Committee in charge of the above scheme, in ignoring entirely the plans he had recommended for their consideration or acceptance, a further strong protest has been published in the news-

papers by the Glasgow Institute of Architects against the somewhat arbitrary and apparently unfair way in which the Committee has proceeded with the important work they have on hand. They state that the plans adopted by the Committee, which were not in any way recognised by the assessor, "are in many vital particulars inadequate and out of date," and that if the reconstruction is proceeded with according to those plans "the infirmary will not conform to the most modern standards of design in this class of building." We understand the plans adopted, without entering into any detail with reference to internal arrangements, will form a magnificent pile of buildings, calculated, unfortunately, from the high altitude of the memorial front (which is likely to prove a very late Jubilee memorial, by the way, of our late Queen) with its spire, to dwarf considerably the cathedral which is immediately adjacent. We are informed that Dr. E. Anderson's reports were somewhat meagre, and that while he recommended several plans, to the entire exclusion of those selected by the Committee, he unfortunately did not enter into detail, giving his reasons for the awards he made to the exclusion of others. The matter has assumed somewhat serious dimensions, as the Institute of Architects is not satisfied with the explanation given by the managers and the Executive in the official statement issued to the public. The Institute suggests that the plans should be submitted to one or more independent hospital authorities of recognised and outstanding position for consideration and report, and further makes the fair proposal that should their contention not be borne out by the report received, they would meet the cost if the Executive object to the outlay involved, while submitting before hand the name or names of the experts proposed on obtaining the necessary facilities from the Committee. As there is considerable diversity of opinion with regard to the plans adopted, and from the firm attitude of such an influential body as the Institute of Architects in the matter, it behoves the Executive to give the subject very serious and thoughtful consideration. They have charge of an undertaking which requires the public to subscribe a very large sum of money, notwithstanding the £90,000 in hand at present. The total cost will exceed a quarter of a million before completion.

**THE NEW PROFESSOR OF MEDICINE IN ST. MUNGO'S COLLEGE.**—Dr. Thomas K. Monro has been appointed to the Chair of Medicine in St. Mungo's College, vacant by the resignation of Dr. Alex. Robertson. Dr. Monro is M.A. and graduated M.B., C.M., at Glasgow in 1888, with commendation, and M.D. with honours in 1895. He was strongly recommended in very flattering terms for the vacant office by Sir Wm. T. Gairdner, whose house physician he was in the Western Infirmary, and also by Professor Osler, of John Hopkins University, Baltimore, who says in his testimonial "that Dr. Monro is well known to us on this side of the Atlantic as an original and careful writer on many medical subjects." After graduating, Dr. Monro studied in Vienna, Berlin, and Paris. His contributions to medical literature are very numerous. St. Mungo's College is to be congratulated on having appointed one to the Chair of Medicine who, in the language of Sir W. T. Gairdner, "will do credit to their choice, and will advance the interest of the College and its students."

## Manchester.

[FROM OUR OWN CORRESPONDENT.]

### THE FUTURE OF VICTORIA UNIVERSITY.

THE proposed disintegration still continues an engrossing topic for discussion in academic circles. On June 29th an important meeting of the Court was held, at which Earl Spencer, Chancellor of the University, presided, and the following resolution was submitted from University College, Liverpool:—"That while gratefully acknowledging the advantages which have accrued to University College, Liverpool, by its association with Victoria University, this Court is of opinion that a

university should be established in Liverpool, and will welcome a scheme for this object upon an adequate basis." Sir John Hibbert, Chairman of the County Council of Lancashire, Professor Rücker, Mr. A. H. D. Acland, Dr. Clifford Allbutt, and others deprecated a dissolution of the great federal University of the North, and Earl Spencer clearly indicated the dangers which might arise from the establishment of several local universities to the cause of higher education. The best opinion evidently deprecates the impetuosity and ill-directed ambition of Liverpool. Strong feeling exists among graduates that a dissolution of the Victoria University would be an act of injustice to them, and, as Earl Spencer expressed it, is it right or desirable to to break up a university which already had a great many men dependent upon it. A great many men had felt much honour in passing the degrees of that university, said Earl Spencer, and he thought they would be exceedingly sorry if the university to which they belonged, and which had conferred honour upon them, should no longer exist, which would be the case if the Liverpool resolution was carried. The general opinion of the Court was finally voiced by the adoption of the following resolution:—"That in order more fully to deal with the resolution of the Court of University College in reference to the establishment of a university in Liverpool, a Committee of the Court be appointed to consider and report, in the event of an application for a university charter being made by University College, Liverpool, what action, if any, should be taken by the Court of the University, and that the authorities of University College be requested to keep the Committee informed of any steps which they may propose to take in the matter." The irreconcilable attitude of Liverpool is well indicated by the following resolution, which was unanimously adopted at a meeting of the Liverpool City Council on the 3rd inst.:—"That this Council has observed with much satisfaction the growth and progress of the University College, and in view of the fact that the college authorities are taking steps to procure the establishment of a separate university for Liverpool records its opinion that it is desirable, in the interests of higher education in the city, that such a university should be founded." Such an eminently parochial point of view may well distress those who hope for a raised standard of medical education in this country. A serious attempt is apparently to be made to Americanise our system of university education. Medical educationalists throughout the country will do well to watch the proceedings which are quietly taking place with regard to Victoria University, as it seems likely that it is premonitory of a phase of thought and line of action which will have far-reaching results on university training in this country. Meanwhile it would be well if medical graduates of the Victoria University could be associated in a graduates' council to watch proceedings and safeguard their own interests.

## Liverpool.

[FROM OUR OWN CORRESPONDENT.]

### PROPOSED UNIVERSITY FOR LIVERPOOL.

THE proposal of the University College, Liverpool, to separate itself from the Victoria University has come upon the Manchester portion as somewhat of a cold douche. It cannot see any necessity for such a move, and it looks upon the proposal as an evidence of some degree of ingratitude. As regards the attitude and sentiments of the University College section, and indeed of Liverpool generally, there can be no ambiguity. The proposal of the College itself—"That while gratefully acknowledging the advantages that have accrued to University College, Liverpool, by its association with Victoria University, this Court is of opinion that a University should be established in Liverpool, and will welcome a scheme for this object upon an adequate basis"—is evidence of this on the part of the College, whilst the resolution of the City Council, passed at a meeting on the 3rd inst., is sufficient evidence of the feeling of the Liverpool public generally.



No special arguments were employed by the Owens College section against the proposal, but it was quite natural that one of such novelty and one so revolutionary should not meet with immediate acceptance. It would have been too much to expect such a thing. However, the College has done well to bring it forward, and a beginning has been made. Looked at impartially, a good deal may be said in favour of the project. The Liverpool University would be a more self-contained institution, a part of its energies would not have to be frittered away in seeking the co-operation of its other half, and a stimulus would be given to it to do its very best to keep abreast of other institutions.

On the other hand, there appears to be only one objection to it, and that is that it would interfere with vested interests and damage the prestige of the Victoria University by the formation of still another licensing body. This would not be of much moment, however; people who are content with the already absurd number of licensing bodies cannot seriously object to the addition of one or two others. In Germany no University is a licensing body; there is but one portal for practitioners, and that is the State examination. Why not do here what has been done in Germany, and sweep away the power of granting licenses from all the present licensing bodies and make one portal—a State examination? All jealousies on the part of present licensing bodies would then cease, degrees would then become simple academic distinctions, honourable distinctions as much as ever, but the degree would be removed out of the sordid atmosphere of licensing for money and the commercialism inevitably associated with it.

### Literature.

#### MAKINS'S SOUTH AFRICAN WAR SURGERY. (a)

This volume is the outcome of the author's experiences as consulting surgeon to the South African Field Force. As such it forms part of what will be doubtless a copious literature, but it may be questioned whether any individual book is likely to be of greater value to the student of military surgery than the one now before us. Mr. Makins took to his task a ripe experience of surgery gathered from many years of work as surgeon and teacher in St. Thomas's Hospital and elsewhere. He has brought the full extent of his powers to bear upon a systematic examination of the immense mass of material rendered available to military surgeons by the prolonged war that is still dragging its slow length along in South Africa. The question of transport is introduced by the statement that its importance is felt from the time of the injury till the time of the arrival of the patient in the mother country. To the surgeon it is of the same vital importance as the carrying of food for the troops is to the combatant general. This view has a little further on the significant rider that a really satisfactory wagon, combining both strength and comfort, still remains to be devised. Illustrations are given of various wagons, hospital trains, hospital tents, and other details that enable the reader to form a graphic idea of the realities described in the text. The difficulties in the way of the surgeon were numerous. Dust, for instance, was everywhere, and, we are told, "often when a bandage was removed an even layer of dust, moistened by perspiration, covered the whole area included with a coating of mud." Flies were another source of annoyance, and mustered in vast numbers within a few days of the pitching of a camp. Indeed, it is not a little remarkable that, under the circumstances, so little septic mischief was encountered. Curiously, the only really acute case of joint pyæmia heard of by the author developed in connection with a blistered toe, followed by cellulitis of the foot. From a series of observations the author was enabled to arrive at the following definite conclusion as to the alleged use of expanding bullets:—"The opinion I formed was against either the very free

use or the great wounding power of so-called expanding bullets of small calibre. I believe that a great number of the injuries which were attributed to the employment of these missiles were produced either by ricochet regulation bullets of small calibre, or by large leaden bullets of the Martini-Henry type." This opinion is of the utmost value, coming as it does from a trained observer who has availed himself of an unusually wide field of observation. From a surgical point of view the book is full of interest. A striking instance of the absence of initial pain was afforded by a man shot through the buttock, the bullet then traversing the abdomen; this patient remained unaware that he had been hit until on undressing he found blood in his trousers, and exclaimed, "Why, I have got this bloody dysentery!" None the less his internal injuries were sufficiently severe to lead to his death within thirty-six hours. A man shot in the pelvis had an attack of retention of urine on the voyage home, and passed a Mauser bullet per urethram. The radiograms are of great interest, their technical quality is excellent. The illustrations include twenty-five plates and seventy-one process pictures, and add considerably to the value of the book. Regional injuries are dealt with systematically and minutely, and the author may be congratulated on having written a volume that is worthy of the best traditions of British surgery.

### Correspondence.

[We do not hold ourselves responsible for the opinions of our correspondents.]

#### THE ANDERSON FUND.\*

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—We shall feel much obliged if you will give us your powerful aid in bringing before the medical profession and the public the following facts in connection with the late Mr. R. B. Anderson, F.R.C.S., whose widow and two orphan sons are now living in Tobago and are in the most straitened circumstances.

A strong representative committee—with power to add to their number—has been formed with the view of appealing for assistance to those members of the medical profession and of the public who knew and sympathised with the hard case of Mr. Anderson which aroused more interest and sympathy than any other professional case of recent years, and raised a most vital point in medical ethics.

Shortly, the history of this case is, that after being for some time in attendance on a private patient in Tobago Mr. Anderson refused to continue his attendance, owing to her husband's personal rudeness to himself. On this an action was brought against him by the patient and her husband, and Chief Justice Gorrie (of Trinidad and Tobago) gave damages against Mr. Anderson for neglect in retiring from the case, although the attendance of another medical man had been immediately secured, and no injury to the patient was proved.

Mr. Anderson resisted this judgment, excessive bail was demanded from him, and in default he was imprisoned, and in the end ruined by this and other illegal acts of judicial oppression. Mr. Anderson then came to England, a Committee was formed to assist him in carrying the West Indian judgments in Appeal to the Privy Council, and Mr. Anderson in person brought an action before the late Chief Justice Coleridge in the Queen's Bench for the recovery of damages against the Colonial Judges. An English special jury gave a general verdict in his favour, with £500 against one of the Judges—Chief Justice Gorrie having died just prior to the trial—but Lord Coleridge gave judgment for the Judge, against Mr. Anderson, and the verdict in his favour, on the ground that no civil action for damages would lie against Judges for acts done in their judicial capacity. This judgment was confirmed on appeal, and from want of funds a further appeal to the House of Lords, and the proposed Colonial Appeal to the Privy Council, were rendered impossible. Finding his legal remedies unsuccessful, owing to the insufficient support he received from the

(a) "Surgical Experiences in South Africa, 1899-1900." By G. H. Makins, F.R.C.S., Surgeon to St. Thomas's Hospital, late Consulting Surgeon to the South African Field Force. London: Smith, Elder and Co. 1901

corporations and associations of the profession, Mr. Anderson began an active campaign of medical reform, by which means alone he saw any hope of proving the justice of his case, and securing for the future the rights of the profession, which were involved in his case, together with others which, in his opinion, required protection.

His life terminated suddenly from heart disease under pathetic circumstances, on November 8th last, and our committee feel that many in the profession, as well as others, will be ready—whether or not they were in agreement with Mr. Anderson's views and methods—to respond to this appeal on behalf of his necessitous family.

Donations "for the late E. B. Anderson Fund" sent, and made payable to the Manager, Union Bank of London, Chancery Lane, London, will be duly acknowledged, and the amount subscribed will be dealt with as our committee, by resolution, may decide.

We are, Sir, yours truly,  
STAMFORD (Chairman).  
TIMOTHY HOLMES (Hon. Sec.)

## Laboratory Notes.

### ESVACH APERIENT WATER.

THE examination of a sample of Esvach Water (Stam and Cross Brand) has shown that it has exactly the same composition as the sample which we examined over two years ago; this being constant greatly enhances its value, as persons using it habitually may thus rely upon always taking the same amount of the aperient salts which this water contains.

It is undoubtedly efficacious for habitual constipation, and the skilful manner in which the ingredients are combined overcomes the griping effects which are so often experienced after the administration of some aperient waters. The excessively bitter taste which frequently leads to the disuse of similar remedies is obviated in an ingenious manner in this water, and bearing in mind the comparatively large quantities of the sulphates of sodium and magnesium which are in solution, this in itself ought to be no small recommendation.

## Medical News.

### The Rontgen Society.

At the annual meeting held July 4th, the following officers and council for the ensuing year were elected. Those marked with an asterisk have not held, during the preceding year, the office for which they are now elected:—President: Herbert Jackson, F.C.S. Vice-Presidents: Lord Blythswood, the Rt. Hon. the Earl of Crawford, D. Ferrier, M.D., F.R.S., J. H. Gladstone, D.Sc., F.R.S., F.C.S., A. A. Campbell Swinton, Dawson Turner, M.D. Council: Barry Blacker, M.D., B.S., J. Mackenzie Davidson, M.B., J. H. Gardiner, F.C.S., A. W. Isenthal, F.R.P.S., E. Payne, M.A., \*C. E. S. Phillips, \*E. W. H. Shenton, L.R.C.P., M.E.C.S., J. J. Vezey, F.R.M.S., H. Snowden Ward, F.R.P.S., J. Wimshurst, F.R.S., Hugh Walsham, M.A., M.D., Chisholm Williams, F.R.C.S. Hon. Treasurer: J. J. Vezey, Esq. Hon. Secretary: F. Harrison Low, M.B.

### A Commission on Butter.

A JOINT Departmental Committee has been appointed to inquire and report as to what regulations, if any, may with advantage be made under section 4 of the Sale of Food and Drugs Act, 1899, for determining what deficiency in any of the normal constituents of butter, or what addition of extraneous matter or proportion of water in any sample of butter, shall, for the purpose of the Sale of Food and Drugs Act, raise a presumption, until the contrary is proved, that the butter is not genuine.

### Lady Doctors Not Required.

FOR over six years the medical staff at Claybury Asylum has included two lady doctors, but the Asylums Committee now state that as "the arrangement is not altogether satisfactory" they have determined to put an

end to it. Recently only one of the lady doctors has been engaged, and she sent in her resignation on learning that it was proposed to abolish the office. The committee propose to make her (Dr. Emily L. Dove), a gratuity of £270 as compensation for the abolition of the office.

### The Oxygen Hospital.

JUDGING from the annual report of the Oxygen Hospital, in Fitzroy Square, this institution continues to demonstrate the fact that an atmosphere of oxygen is strikingly favourable to the repair of certain forms of chronic ulceration. The returns show very clearly that intractable ulcers of the leg do heal in a very remarkable way under its influence, and if this method of treatment has not come into more general use this is doubtless due to the fact that it entails the use of sundry appliances hardly available outside the walls of a hospital. In all, eighty-one cases were treated during the past year, of which fifty-nine were discharged as cured, and twenty-two remain under treatment. The cost per patient per week does not exceed £1 7s., and the average stay in hospital is three months.

### JAN 15 1902 Deaths under Chloroform.

THE first case in which Dr. Waldo, the newly-appointed Coroner for the City of London, had to exercise his functions was that of a lad, aged 12, who died under chloroform at St. Bartholemew's Hospital, after an accident. Death was attributed to the weak state of the patient, and the usual verdict was returned. A similar catastrophe is reported from Barry, the victim being a married woman, age 32, who had been anaesthetised by Dr. O'Donnell prior to the removal of retained membranes after miscarriage. As usual, no details are forthcoming, and the stereotyped verdict was returned.

### The Westmeath Tragedy.

AT Westmeath Assizes last week, Dr. Edward Thomas French was charged with the wilful murder of his wife on April 6th last, at their residence at Glasson, near Athlone. Dr. French was Medical Officer of Glasson District, Athlone Union. From the evidence it appeared that the prisoner, aged about 60, who had been for more than thirty years attached to the Glasson Dispensary District, and who married the deceased lady about twenty-five years ago, was in the habit of drinking to excess, and while under its influence was most excitable. During the evening of April 5th the servants were alarmed by a loud scream, and on rushing to the room observed Mrs. French endeavouring to escape from her husband, who held in one hand a hammer and the other a surgical knife. She said she had been stabbed. The servants caught the doctor and took the knife. Mrs. French ran down some steps to the garden and to the front door, where she fell, and expired in about twenty minutes. There was a deep wound under the right breast, and the liver was pierced and the apex of the heart wounded. For the defence Dr. Fitzgibbon and Mr. Ormsby, F.R.C.S., of Dublin, deposed that the prisoner was suffering for years from a chronic inflammatory disease of the scalp of his head, which undoubtedly would affect his brain, and they believed he was not accountable. Drs. Smart, Shanley, and Kelly corroborated. In charging the jury Lord Justice Holmes said it would be a serious thing to condemn a man who was not responsible, but it would also be a most melancholy thing if they should come to the conclusion that a man was irresponsible when he was actually responsible. The prisoner was a drunkard, and in recent times was more frequently drunk than sober. It was possible that he was a dipsomaniac. His Lordship further said that they could not come to any conclusion from Dr. French's actions during the day of the crime, but that he was perfectly sane. The jury, after a short absence, returned a verdict of guilty of manslaughter. His Lordship said the manslaughter was the most serious one that could be, and sentenced the prisoner to penal servitude for life.

### British Pharmaceutical Conference—The Dublin Meeting.

THE British Pharmaceutical Conference was established in 1863 for the encouragement of pharmaceutical research and the promotion of friendly intercourse and union among pharmacists of the United Kingdom, and

now embraces about 8,000 members. Meetings have been held yearly in different centres, that for 1899 in Plymouth, 1900 in London, and this year the conference have accepted an invitation to hold their meeting in Dublin, it being twenty-two years since a similar visit was paid to the Irish metropolis. The conference commences on Monday, July 29th. Under the presidency of G. C. Druce, Esq., M.A., F.L.S. (Mayor of Oxford) the scientific meetings will be held in the Lecture Theatre of E.D.S., when papers dealing with original investigation of drugs, their adulteration and impurities, will be read and discussed and collections of rare specimens examined. For the enjoyment of the visitors a special programme of entertainments and excursions has been arranged by the Local Reception Committee. At least 400 visitors are expected from across the Channel, and hotel accommodation has been secured for these in the leading hotels. By kind permission of the Right Hon. the Lord Mayor, a luncheon will be given in the Round Room of the Mansion House on Tuesday and Wednesday.

**St. John of Jerusalem.**

MONDAY, June 24th, was the festival of St. John the Baptist, when the members and associates of the Order attended Divine Service at St. John's Church, Clerkenwell, the sermon being preached by the Bishop of Salisbury, one of the chaplains. At the general assembly which took place the same afternoon allusion was made to the great services rendered by the Ambulance Department, and it was mentioned that over two thousand men of the Ambulance Brigade had served as hospital orderlies in attendance on the sick and wounded in South Africa.

**Pass Lists.**

**Royal University of Ireland.**

The undermentioned candidates have passed the First Examination in Medicine, Summer, 1901:—John W. Beirne, Charles D. Bell, Samuel Bradbury, Henry W. Brennan, Herbert W. Carson, Robert Chambers, L.L.B., Robert G. Clements, Robert G. G. Croly, Arthur G. Cummins, James S. Dickey, James Donnelly, John Finnigan, Isaac Flack, James Flack, James B. Hackett, Adam Hill, William J. Hill, Robert Jameson, Sch., Edward Kavanagh, James Kelleher, Robert Ledlie, Andrew Leitch, John Lilley, Robert J. Lytle, Denis T. MacCarthy, William McKee, Albert V. M'Master, Samuel M'Murray, James Magill, Thomas J. Magill, Timothy Meagher, Charlotte E. Mitchell, Timothy O'Driscoll, Michael J. O'Grady, Edward M. O'Neill, John J. O'Reilly, William B. Purdon, Campbell G. Robb, Gabriel V. Ryan, Maurice P. Scanlon, James Shaw, Michael Shipsey, Patrick Stern, William M. Thomson, Stephen M. Walsh, James Warnock, Harry C. Watson, Jemima B. C. White, Wm. R. B. Whitfield.

The undermentioned candidates have qualified on their answering to present themselves for the further Examination for Honours:—John W. Beirne, Charles D. Bell, Samuel Bradbury, Robert Chambers, L.L.B., Robert G. G. Croly, Arthur G. Cummins, James S. Dickey, James Donnelly, James Flack, William J. Hill, Robert Jameson, Sch., Andrew Leitch, Albert V. M'Master, Timothy O'Driscoll, Campbell G. Robb, Gabriel V. Ryan, Maurice P. Scanlon, Patrick Stern, James Warnock, Harry C. Watson.

**Royal College of Physicians and Royal College of Surgeons, Ireland.**

The following candidates have passed the first professional examination A in all subjects:—1. Honours in order of merit: E. L. Sheridan, I. Allau, W. W. Boyce, Miss C. E. O'Meara, R. A. Brown, T. W. Brown. 2. Pass: Alphabetically: A. C. Adams, J. M. Alcorn, E. V. Budge, W. C. Cardon, S. C. Clark, T. Coffey, S. G. Condon, J. Corboy, F. X. Costello, V. J. Cullen, E. F. O'T. Dickenson, T. A. Flynn, D. Hampson, B. C. McC. Hannan, P. E. Hayden, J. M. Hayes, E. Hayes, J. Leonard, E. P. Maher, W. P. Morton, D. McCormack, W. J. McCormack, H. V. McKeogh, A. N. McLaughlin, R. A. Odum, W. C. T. Robey, E. Smith, R. H. Smythe,

P. D. Sullivan, W. Walsh. B. Completed the examination: M. Ambrose, L. L. Davys, T. J. Golding, H. Hosty, D. McLaughlin, T. J. Sinnott, G. B. Spencer, Geo. F. Wright.

**Royal College of Physicians and Surgeons, Ireland.**

The following candidates have passed a special examination for the Diploma in Public Health:—Hampton Atkinson Gray, M.D., Univ. Dubl.; Joseph Patrick Frengley, F.L.C.S.I.; John Grant Warren, L.R.C.P. and S.I.

**Society of Apothecaries of London.**

The following candidates have passed the Primary Examination, Part I.:

Biology.—G. E. Austin, F. C. M. Gabites, C. A. Sampson.

Chemistry.—G. E. Austin, F. C. M. Gabites.

Materia Medica and Pharmacy.—A. Bernfeld, A. G. Gamble, G. B. Messenger, C. A. Sampson, C. J. Taylor, B. B. Westlake.

The following candidates have passed the Primary Examination, Part II.:

Anatomy.—A. J. Ambrose, G. C. M. Davies, B. C. Ghosh, T. W. S. Hills, H. M. Huggins, C. Kellgren, G. Nunn, C. H. Osmond, O. P. N. Pearn, E. H. Price, E. C. Richards, R. J. S. Verity, S. J. Weinberg.

Physiology.—H. Bacon, G. C. M. Davies, B. C. Ghosh, T. W. S. Hills, H. M. Huggins, A. C. Jenkins, T. L. A. Jones, C. Kellgren, G. Nunn, O. P. N. Pearn, E. H. Price, G. H. Rains, B. C. Richards, S. H. Sugden, S. J. Weinberg.

**Navy Medical Service.**

The session of instruction at the Royal Naval Hospital, Haslar, terminated on June 26th, when the fourteen surgeons under instruction, who had obtained their commissions after the competitive examination in London some months previously, received appointments to His Majesty's ships on the determination of their seniority by the sum-total of the marks obtained in London and at Haslar. The following prizes were awarded, viz.: The Gold Medal to Surgeon A. J. Wernet and the Microscope and the Silver Medal and books to Surgeon E. Cox. The Director-General of the Medical Department of the Navy, Sir Henry Norbury, K.C.B., M.D., in distributing them, complimented all the officers highly on the very favourable report which he had received from the Inspector-General and the officers of the professional staff as to the great interest they had shown in the subjects which formed the course, as well as on the general zeal and ability they had evinced during the time they had been under instruction. Surgeons in order of seniority:—

- |                                      |   |
|--------------------------------------|---|
| 1. E. Cox, B.A., M.B. 6,659          | 8. T. F. O'Keeffe, M.B. ... 4,681       |
| 2. J. MacDonald, M.D. 6,168          | 9. E. F. Ellis ... 4,472                |
| 3. A. La P. Darley ... 5,656         | 10. D. V. Lowndes ... 4,250             |
| 4. A. J. Wernet ... 5,631            | 11. G. C. C. Ross, B.A., M.B. ... 4,245 |
| 5. C. E. C. Stanford, M.B. ... 5,203 | 12. P. F. Alderson ... 4,032            |
| 6. A. E. Thomas ... 4,955            | 13. H. C. Woodyatt ... 3,855            |
| 7. W. E. Ruttledge ... 4,826         | 14. J. Thornhill, M.B. 3,848            |

**The Indian Medical Service.**

The following is a list of the surgeons on probation for the Indian Medical Service who have been successful at both the London and Netley examinations. Combined London and Netley marks:—

- |                             |                             |
|-----------------------------|-----------------------------|
| Charles, G. E... 6,168      | Foster, H. B. ... 4,680     |
| M'Kendrick, A. G. ... 5,959 | Butt, G. B. ... 4,544       |
| Moes, O. St. J. ... 5,672   | Kerans, G. C. L. ... 4,507  |
| Little, J. W. ... 5,413     | M'Conaghey, C. B. ... 4,488 |
| Sumner, F. W. ... 5,285     | Illins, H. W. ... 4,395     |
| Nutt, H. B. ... 5,234       | Browne, E. W. ... 4,390     |
| Barnee, J. A. ... 5,073     | Christian, J. B. ... 4,216  |
| Ritohie, W. D. ... 5,014    | Murphy, A. ... 4,161        |
| Scott, N. E. H. ... 4,914   | Thompson, F. T. ... 4,124   |
| Fleming, J. K. S. ... 4,873 | Brassey, L. P. ... 3,881    |
| Hepper, E. C. ... 4,819     | Marr, C. F. ... 3,843       |
| Southon, C. E. ... 4,803    | Box, S. ... 3,761           |
| Fowler, G. ... 4,685        | O'Neill, P. L. ... 3,547    |
| Husband, J. ... 4,680       |                             |

## Notices to Correspondents, Short Letters, &c.

**✉** CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

MR. WM. TEBB.—Your letter having already appeared in the lay press it is unnecessary to give space to it in our columns.

TRUTH.—The extraordinary mortality to which you refer in Calcutta was for the week ending March 23rd of present year, when it reached 143.6 per 1,000 of the population, but these figures are valueless for comparison in the other case.

JUNIOR ASSISTANT will find vacancies advertised in our present number under the London County Council, the Metropolitan Asylums Board, Chester General Infirmary, &c., such as he seeks.

### MODERN METHODS!

ELDERLY Practitioner: The child appears to be teething.  
New Graduate: Impossible! The bacteriological diagnosis discloses no trace whatever of the characteristic teething bacillus.—*British and Colonial Druggist.*

DR. JOHN N. SHEE.—The question is a natural one in view of the attitude taken up by this journal on the subject. In reply, it may be stated that the announcement got in by an oversight, and when discovered it was unfortunately too late to withdraw.

ONCEBORN.—The use of the tetanus antitoxin has not proved successful in all cases of tetanus. But the value of it is shown by the fact that it has reduced the mortality in the disease from 90 to 39 per cent.

### A GOOD HOSPITAL STORY.

In a recent number of the *St. Mary's Hospital Gazette* we find the following story told *propos* the resignation of Mr. Critchett: A man having been jammed in a traction engine was brought to the hospital and admitted. As he was suffering from diplopia, Mr. Critchett's advice was sought. Discovering a paralysis of one of the ocular muscles, he gave him large doses of iodide of potassium. The house surgeon wished to try galvanism. After a few weeks the paralysis was cured, and the diplopia had vanished. The house surgeon asked Mr. Critchett which treatment he thought had cured the diplopia. Mr. Critchett said, "I think we might cry, 'honours easy,' for I took him by assault and you by battery."

DI. M. (Bellast).—B Naphthol is a somewhat irritating substance if allowed to come into contact with the walls of the stomach, but it is practically non-toxic, owing to its extreme insolubility in aqueous fluids.

## Diary for the Week.

### ENGLAND.

WEDNESDAY, JULY 10TH.

DERMATOLOGICAL SOCIETY OF LONDON (20, Hanover Square, W.).—5.15 p.m. Consultation on cases of clinical interest.

THURSDAY, JULY 11TH.

BRITISH GYNECOLOGICAL SOCIETY (20, Hanover Square, London, W.).—At 8 p.m. Dr. H. P. Noble, of Philadelphia, on "Degenerations and Complications of Uterine Fibromyomata."

FRIDAY, JULY 12TH.

BRITISH LARYNGOLOGICAL, RHINOLOGICAL, AND OTOLOGICAL ASSOCIATION (11, Chandos Street, W.).—Special discussion on "Tumours of the Pharynx," to be opened by Dr. Robert Woods, Dublin. Also cases and specimens by the President, Mr. Mayo Collier, Dr. Barclay Baron, Mr. Lennox Browne, Dr. Dundas Grant, &c.

### IRELAND.

WEDNESDAY, JULY 10TH.

PHARMACEUTICAL SOCIETY.—11 a.m. Examination.

THURSDAY, JULY 11TH.

DUBLIN SANITARY ASSOCIATION (42, Dame Street).—4.30 p.m. Council Meeting.

MONDAY, JULY 15TH.

1st, 2nd, and 3rd Professional Examination, Apothecaries Hall. Final Professional Examination, Royal Colleges Physicians and Surgeons.

## Appointments.

GORDON-SMITH, H., M.A., B.C.Cantab., Resident Medical Officer to the West London Hospital.

GULLAN, A. GORDON, M.D.Lond., F.R.C.S.Eng., L.R.C.P.Lond., Physician to the Stanley Hospital, Liverpool.

HEATHER, LEWIS DANIEL, L.R.C.P.Lond., M.R.C.S., Medical Officer of Health for the Hay (Brecknockshire) Urban and Rural District Councils.

HICKES, THOMAS, M.B., C.M.Edin., Medical Officer of Health by the Paincastle (Brecknockshire) Rural District Council.

JONES, OWEN CLAYTON, M.B.Oxon., M.R.C.S.Eng., L.S.A., Medical Officer for the Ilfracombe District of the Barnstaple Union.

LITTLEJOHN, THOMAS H., M.B., C.M.Edin., F.R.C.S.Eng., D.P.H., Medical Officer of Health, Hampstead.

MARSH, JOHN HADLEY, M.R.C.S.Eng., L.R.C.P.Lond., Honorary Surgeon to the Macclesfield General Infirmary.

MCCALL, EVA, M.B., Ch.B.Glasg., Assistant Resident Medical Officer at the Birkenhead Union Infirmary.

MCKENZIE, J. M.A., M.B., Ch.B.Aberd., House Surgeon to the West London Hospital.

MOORE, R. G., M.B., Ch.B.Vict., D.P.H.Lond., Medical Officer of Health to the County Borough of Huddersfield.

PENDLEBURY, HERBERT S., F.R.C.S.Eng., Surgeon to the Royal Hospital for Women and Children, Waterloo Bridge, London.

SCOTT, D. WOLSELEY, L.R.C.P., L.R.C.S.Eng., L.F.P. & S.Glasg., Medical Officer to the Hendre Morgern and Henllis Vale Collieries.

SHEILD, A. MARMADUKE, F.R.C.S., Consulting Surgeon to the Royal Hospital for Women and Children, Waterloo Bridge, London.

## Vacancies.

Chester General Infirmary.—House Physician. Salary commencing at £90 per annum, with board, residence, &c. Also a House Surgeon. Salary commencing at £100, with board, residence, &c. Applications to the Chairman of the Board of Management, Secretary's Office, 29, Eastgate Row, Chester. (See advt.)

Croydon Union Infirmary, Maryday Road, Croydon.—Resident Assistant Medical Superintendent and Dispenser. Salary £120 per annum, increasing to £150, with furnished apartments, rations, and washing. Applications to the Clerk of the Guardians.

Cumberland and Westmoreland Asylum, Garlands, Carlisle.—Senior Assistant Medical Officer, unmarried. Salary £150 a year, rising to £180, with board, lodging, &c.

Devon County Asylum, Exminster, near Exeter.—Third Assistant Medical Officer. Salary £125, rising to £150, with board, lodging, &c.

King's College, London.—Professor of General Pathology and Bacteriology. Also Assistant Physician (or Surgeon) for Diseases of the Throat. Conditions and other particulars will be supplied by the Secretary.

Liverpool Port Sanitary Authority.—Assistant Medical Officer of Health. Salary £300 per annum. Further particulars of the Town Clerk, Municipal Buildings, Liverpool.

London County Asylum, Claybury, Woodford Bridge, Essex.—Junior Assistant Medical Officer, unmarried. Salary £150 per annum, with board, furnished apartments and washing.

London County Asylum, Banstead.—Medical Superintendent. Salary £1,000 per annum with house, rates, taxes, and water supply free. Forms of application to be hid of the Clerk to the Asylums Board, London County Council. (See advt.)

Metropolitan Asylums Board.—Assistant Medical Officers (unmarried) at the Fever and Small-pox Hospitals. Salary £160 per annum, rising to £200, with board, lodging, attendance, and washing.

Newcastle-upon-Tyne City Lunatic Asylum.—Second Assistant Medical Officer, unmarried. Salary £140 a year rising to £160.

Nottingham General Dispensary.—Senior Resident Surgeon. Salary £200 per annum, increasing by £15 every year. Also two Assistant Resident Surgeons. Salaries £160 per annum each, increasing by £10 every year, furnished apartments, attendance, light, and fuel. Unmarried.

Owens College, Manchester.—Senior and Junior Demonstrator in Physiology. Stipends £150, rising to £200, and £100 rising to £150 respectively. Applications to the Registrar.

Plymouth Borough Asylum.—Assistant Medical Officer, unmarried. Salary £150 per annum, rising to £200 per annum, with furnished apartments and board and washing. Applications to the Medical Superintendent at the Asylum.

West Riding Asylum, Wadley, near Sheffield.—Third Assistant Medical Officer. Salary £150, with board, &c., rising to £200.

Al-c Fifth Assistant Medical Officer. Salary £140 per annum, with board, &c., rising to £160.

Willesden Urban District Council Isolation Hospital.—Medical Superintendent and Assistant Medical Officer of Health. Salary £350 per annum with allowance of £50 per annum for residence.

## Births.

BENNETTS.—On July 1st, at Bозest, Northants, the wife of F. Bennetts, M.R.C.S., L.R.C.P., of a daughter.

GROSS.—On July 3rd, at 100, Commercial Road, London, E., the wife of Phineas Gross, L.R.C.P.Lond., M.R.C.S.Eng., of a son

## Marriages.

ANDREWS—HORNER.—On July 4th, at the Parish Church, Tonbridge, Henry Arthur Andrews, M.R.C.S., of Tonbridge, fourth son of the late Martindale Andrews, of London, to Amy Diana Frances, only daughter of the late A. C. Horner, M.R.C.S., of Lyons, Tonbridge.

BULL CROOK.—On July 3rd, at the Church of St. Peter and St. Paul, Weobley, Herefordshire, Harry Ashworth Bull, M.R.C.S.Eng., L.R.C.P.Lond., second son of James Bull, J.P., of Birch Hall, Ingestree, Staffs., to Edith Marian, second daughter of the Rev. James Crook, vicar of Weobley.

KIERNEBER MASON.—On July 2nd, at Framfield Parish Church, Sussex, Willie Evan Melfort, only surviving son of H. B. Kierneber, L.R.C.P. and L.R.C.S., Sydney, Australia, to Charlotte Gordon, only surviving daughter of the late Lieut.-Col. E. G. S. Mason, Belfast, Ireland.

## Deaths.

BELL.—On July 5th, at Bedford, after a very short illness, Zebec Stewart, widow of William Bell, M.D., Inspector General of Army Hospitals, aged 74.

HUNTER.—On July 3rd, at the Popters, Pontypridd, Robert Charles Hunter, M.R.C.S., L.R.C.P., J.P., aged 66.

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## Original Communications.

### NÆVI AND THEIR TREATMENT. (a)

By THOMAS H. KELLOCK, M.A., F.R.C.S.,

Assistant Surgeon to the Middlesex Hospital, and to the Great Ormond Street Hospital for Sick Children, London.

It is sometimes profitable and interesting to consider minor subjects which acquire importance from the frequency of their occurrence, and, as in *nævi*, from the good that can so often be done in relieving a patient of what is always unsightly, and, it may be, a cause of considerable inconvenience, for, situate as *nævi* so often are on exposed parts of the body, it is a matter of no little importance to those who have to earn their livelihood, as well as for appearance sake, that these disfigurements should be as far as possible, and as soon as possible, remedied.

Of the *pathology* of *nævi* there is comparatively little to say; structurally they are composed of an agglomeration of slender blood-vessels, with very little muscular tissue in their walls, lined with the usual endothelium, separated from each other, and at the same time bound together, by a small amount of fibrous tissue. The size of these vessels differs in the several varieties; in the superficial ones they are very small, little more than capillaries, whilst in the deeper so-called subcutaneous variety they are often found of considerable size, and in the latter the whole tumour is lobulated and enclosed within a thin capsule of connective tissue, which is not found in those more superficially situated. The circulation of the blood is a little peculiar, arteries lead up to them, and veins carry the blood away, and yet in excising them the vascularity of the surrounding parts is not very great. In the bright red superficial *nævi* the circulation is rapid, as shown by the way in which the colour returns after they have been pressed upon; and if cut into, or penetrated by an ulcer they bleed readily, but owing to the thinness of the vessel walls the hæmorrhage is easily controlled by pressure. In the deeper ones the circulation is not so rapid, as shown by their much darker colour; if cut into, dark blood issues in a feeble stream and the hæmorrhage will often cease spontaneously when the vessels of which they are composed have been emptied. That part of the skin which covers a superficial *nævus* is always badly nourished, in spite of the free circulation underneath, and if ulceration takes place in it from any cause it spreads rapidly and is healed slowly and with difficulty.

Excluding cases of so-called *nævus* of the skin of the legs and other parts which arise in elderly people—women especially—and which are really dilatation of pre-existing veins and capillaries—varicose veins they might more properly be called—and those cases

of angioma of the liver which are said to commence in adult life, but which cannot probably be classed with *nævi*, it may be said that *nævi* are almost without exception congenital; they increase in size, it is true, after birth, rapidly and extensively sometimes, but there is always a something, however small, present at the time of birth. Of their causation little or nothing is known; whether they are hereditary is doubtful, but it is, without doubt, common to find several children in the same family affected. It is a curious fact how many more girls than boys are affected by *nævi*. Of eighty-three cases, fifty-seven were girls, and of ten cases which were so extensive as to necessitate their admission to the hospital for operation during the year 1900, only one was a male child.

*Nævi* are essentially an affection of the epiblastic layer of the embryo. They are found on almost every part of the skin, and on mucous membranes at the orifices where the epiblast turns in to join the hypoblast, as at the mouth and anus. If they occur in the mucous membrane of the alimentary, respiratory or urinary tracts, they do not seem ever to be discovered or to give rise to any symptoms. The following is the order in frequency of the parts of the body affected:—Trunk, face, scalp, upper extremity, lower extremity. The female external genitals are often affected; not so the penis and scrotum, but this may possibly be accounted for by the relative infrequency of *nævi* in male children.

*Nævi* are generally divided into three classes: The superficial cutaneous, or capillary; the deep, subcutaneous, cavernous, or venous; and the mixed, which are a combination of the other two varieties. There are, however, two varieties of the first class which are often seen, the diffuse and the circumscribed. The first of these, the diffuse—perhaps better termed a *nævoid* condition of the skin—is extremely common in very young children, situate in the upper eyelids, on the forehead in the shape of a V, the apex at the root of the nose, and the base at the junction of the forehead and scalp, and also among the hair immediately under the occiput. Of the circumscribed superficial *nævi* there are again two kinds, some—the majority—are *flat*, hardly rising above the level of the surrounding skin; in passing the finger over them except for the sensation of a slight increase in the temperature, hardly any abnormality is recognised. The edges of these are often very irregular, and at times their limitation is not very marked. The others are *raised*, almost pedunculated at times, looking like velvet plush cushions; they are always sharply marked off from the surrounding healthy skin, and are very satisfactorily treated by excision. The deep, subcutaneous, or venous *nævi* generally form darkish coloured tumours which project but slightly on the surface of the body; certain situations, however, modify this, and they may form projecting or even pedunculated masses.

(a) Abstract of a Lecture delivered at the Hospital for Sick Children, Great Ormond Street.

There is a form of deep nævus which is sometimes associated with tumours and new growths. They are generally termed nævi, but can hardly be classed pathologically with those found in the skin; they are composed of a collection of thin-walled vessels which are separated from each other by much more, and much looser, connective tissue than is found in the cutaneous variety, and these vessels are, so to speak, in the direct circulation, not forming a *cul de sac*, as in the case of ordinary nævi; in fact, they are reminiscent of the condition found in a varicocele, and probably the two conditions have a good deal in common. Of such is the collection of vessels found in those rare cases of congenital unilocular cyst of the axilla, forming a pedicle to this, passing up under the clavicle, and connected with the deeper structures in the lower part of the neck.

A superficial nævus may be associated with a tumour of a more important kind. It is quite common to find the base of a spinal meningocele or myelocele surrounded by a superficial nævus, and it is necessary to be careful in dealing with a tumour of the back situated in or near the middle line on whose summit there is a nævus; it may, of course, be only a nævus of the mixed variety, but the superficial nævus may also be a very useful danger signal, for the tumour beneath it may be connected with the spinal meninges or with the spinal cord itself.

Nævi are found, too, in association with other congenital tumours; it is not uncommon to find them in the skin covering hygromata, or in the skin of a limb affected by lymphatic hypertrophy.

Nævo-lipoma is a term used sometimes, but it is a condition rarely seen. The congenital lipomata have peculiarly few blood-vessels, and it is uncommon to find more than the ordinary subcutaneous fat about a deep nævus.

**Prognosis.**—Parents will ask what will happen to the nævus if it be left alone? This question will probably be asked, not about one on the face or other visible part—these they are always naturally anxious to have removed—but about those on the trunks or limbs where they are not likely to be seen. Even these, as a rule, mothers are anxious to have removed, for in the first place they seem to have an idea that any disfiguring mark or deformity in their child is a sort of disgrace to themselves; and secondly, they think that, should a nævus be cut or knocked, the child will bleed to death. The bright red colour has probably something to do with the latter idea, which alarms them unnecessarily, for, although it is true that if cut, bleeding and rather free bleeding does occur, yet the hæmorrhage can be easily stopped by the mildest pressure; at the same time it must be borne in mind in this, as in every other condition, that loss of blood to any extent is always serious in a young body. A more real danger in nævi of any size is ulceration with sloughing and possibly hæmorrhage as a complication. An injury or continued irritation may start this, and once started there is little tendency for it to cease until almost the whole tumour has been destroyed. The ulceration often stops near the edge, leaving a ring of nævus near the healthy skin, and this ring, instead of being destroyed by the ulceration, is apt to be, as it were, stimulated in growth, and to spread outwards into previously unaffected skin. If the nævus be large, ulceration taking place in this way may be serious. On the other hand, if the growth be small and the ulceration extend to its edge, it may result in a cure, but while this is going on there is the danger of sepsis and hæmorrhage, and the cure, after all, is not a very scientific one. It is possible to imagine malignant disease, sarcoma, or epithelioma arising in a nævus. In addition to these dangers there is always the chance of a nævus spreading, and it is rather remarkable how rapidly this sometimes

takes place. A superficial nævus, which at birth is hardly visible may attain a very considerable size in a few months, or even weeks, and a crop of similar growths sometimes springs up around the original one—a good argument in favour of early removal. There seems, however, a limit to their growth, which does not go on indefinitely, but ceases after a time and the tumour becomes stationary. The cause of this cessation of growth is just as obscure as that of its occurrence. The deep nævi very often increase in size after birth, but not nearly to the extent the superficial ones do. These, then, are the risks that are run by leaving a nævus untreated; on the other hand, some of them may spontaneously disappear partially or entirely as the child grows. The nævoid condition about the eyelids, forehead, and occiput always does so, and that too in a relatively short time; if looked for when the child is a year old probably no trace will be found. The deep cavernous nævi rarely, if ever, disappear without treatment, but the diffuse superficial ones sometimes do, and it is not uncommon to watch them getting less bright in colour, although their size may not diminish, and eventually they may become hardly noticeable.

**Treatment.**—There are so many ways of dealing with nævi that perhaps the best plan will be to consider the methods *seriatim*, and under each heading the advantages and disadvantages of the method and the cases for which it is suitable. For, consisting as nævi do of several varieties, and situate as they are on so many parts of the body, no one plan can be adopted for them all, and it is necessary to consider for each which of the various methods should be chosen. **Excision.**—This has the advantage of thoroughly removing the growth at one operation. Union by first intention can be obtained; the scar left is the least possible, and becomes practically imperceptible as the child grows, and there is no danger of recurrence if the excision has been properly carried out. It cannot, of course, be practised in those situations where the necessary drawing together of the skin would cause disfigurement. An anæsthetic is necessary, and the hæmorrhage, even where the greatest care is taken to cut wide of the growth, is often considerable, and not to be too lightly considered in the case of a young baby.

The incisions should be planned so as to be completely clear of the superficial part of the growth, and yet to remove the least possible amount of healthy skin. For the deep ones it is generally possible, by turning back skin flaps, to avoid sacrificing any skin at all. Sometimes two curved incisions, one on either side, sometimes a triangular wound, where the edges are united afterwards in a triradiate fashion, or, again, a quadrilateral wound, united afterwards in "envelope" shape, will answer best. An infant's skin is wonderfully elastic, and it is remarkable how large a growth may be excised in this way and the edges brought together without undue tension, possibly with the help of a little undercutting of the surrounding parts; even if the edges cannot be brought quite together, the remaining surfaces can be grafted immediately, and a very good result be obtained; but if this has to be done it is advisable not to be too free with the suturing, it is better to graft rather more than appears necessary so that the small amount of contraction that takes place under the grafted surface may not cause disfigurement by dragging on an already tightly sutured part. Horsehair sutures are very unirritating, and leave less mark than any others; they should be removed at the earliest possible date, or the little white marks they leave by the side of the scar make the latter more noticeable; a collodion dressing can often with advantage be substituted for the sutures after two or three days

This refers, of course, to operations on visible parts of the body; in other parts the marks do not matter much. There are a few situations where excision cannot very well be carried out, where a nœvus invades the whole thickness of the lips, cheeks, auricle, or eyelids, in the tongue, on the gums, or where it involves important structures, such as the parotid gland; or in a female child where a nœvus involves the breast and excision would mean the sacrifice of the gland, which should not be done unless every other form of treatment is contra-indicated. A common situation for a mixed nœvus is in the scalp over the anterior fontanelle. Here excision is quite suitable; the dangers of interfering with one in that situation have been much exaggerated. They pulsate, it is true, but the pulsation is only communicated, and between them and the superior longitudinal sinus and membranes of the brain there is the thick fibrous membrane closing the fontanelle.

Subcutaneous tumours at either of the fontanelles, at the root of the nose, or at the inner angle of the orbits, may be meningoceles or dermoid cysts, both of which communicate generally with the interior of the skull; these tumours are not so often accompanied by nœvi as the similar ones in the back, but the combination might be met with and lead to great difficulty in treatment if their nature had been overlooked.

*Electrolysis* is another method of treating nœvi. It is a rather tedious performance, painful, and so needing an anæsthetic, probably on many occasions. If, as sometimes happens, sloughing occurs about the spots where the needles were inserted, rather unsightly marks are apt to be left. A large mass of fibrous tissue is often left in the situation of a deep nœvus treated in this way, which is in itself a disfigurement, but which can sometimes be subsequently removed by excision. Electrolysis has the advantage that it is bloodless and can be employed in certain parts of the body where other methods of destruction are contra-indicated, where, for example, a nœvus involves important structures, such as the deep muscles of the face, cheeks, lips, tongue, eyelids, female breast, &c. For superficial nœvi it is rarely needed; if it destroys them it often does so by causing ulceration, and this can be brought about more thoroughly and quickly by other methods if excision is out of the question.

In employing electrolysis there is no need for a very strong current; that from eight to twelve cells is generally sufficient, and the current should be allowed to pass through the growth for from five to ten minutes at a sitting. The needles should be insulated to within half an inch of their points, and passed into the growth far enough to prevent any non-insulated part being in contact with the surface, or ulceration is almost sure to occur at the points of insertion.

*Cauterising Agents.*—The actual cautery, galvano-cautery, and strong acids are useful in destroying superficial nœvi which for some reason cannot be excised.

An anæsthetic is hardly necessary when cauterising a nœvus, especially if it be small. The pain appears to subside very rapidly on the application of a little ointment, or better, dry powder. Whichever of the cauterising agents is employed, it must be done thoroughly, or after a few days the scab that has resulted will come off, and the nœvus be found as vigorous as ever underneath it. For this reason the acids, nitric or sulphuric, are perhaps better than the cautery, as their effect is more penetrating; but they require more care in their application. It is a pitiful thing to see a child's face scarred by acid that has been applied carelessly to a nœvus in infancy; to avoid this, when using any kind of caustic, the surrounding skin should be protected by vaseline or

some simple ointment, and, of course, great care taken that only a very small quantity of the acid is carried by the glass rod or other instrument used. It is hardly necessary to add that especial care in this respect should be taken when operating near the eye. A few of the deep nœvi which cannot be excised, and which do not respond to treatment by electrolysis, may be dealt with by turning back a flap of skin or mucous membrane and inserting the actual or galvano-cautery in different directions, and then the skin flap replaced. A slough will very likely come away if it has been thoroughly done, but the result is sometimes most satisfactory, and the subsequent scarring much less than would have been expected.

*Crushing* a nœvus is a plan that has not much to recommend it.

*Ligatures* was once a recognised mode of dealing with deep nœvi, especially those on the scalp, and in the older text-books on surgery rather elaborate directions are given as to the art of tying the ligatures subcutaneously.

There is also the practice of *injecting* nœvi to cause the coagulation of the blood they contain. Various substances have been used for this purpose, such as perchloride of iron, carbolic acid, &c. It is possible it might be done successfully in a part where it would be feasible to put a clamp or temporary ligature round the growth to prevent the clotting spreading too far, or the clot separating, as in the lips or tongue. The danger of subsequent sloughing must, however, be great, and there are other methods of treatment more scientific and of more proved value.

It is said that small nœvi may be cured by the repeated application of ethyl chloride or collodion, which act by causing contraction of the growth in much the same way as elastic pressure. It would be a tedious way of dealing with them at the best, and it is not much to be wondered at that the method is not much employed.

Neither these substances nor those which ordinarily cause muscular contraction of the walls of the blood-vessels can have much effect on a nœvus in this way, on account of the very small amount of muscular tissue which exists in them.

Of the treatment by *elastic pressure* it can only be said that if it be sufficient to cause effect, that effect would probably be a slough, and if the pressure were not sufficient to produce this, the nœvus would probably be unaffected. To attempt to regulate the pressure of a bandage nicely enough to strike the mean between these, and so cure the nœvus by keeping it empty of blood, is an undertaking that would hardly commend itself.

In conclusion, there is a method of treatment which probably exists more as a popular delusion than as a surgical proceeding, that by vaccination. Owing to the thinness of the walls of the blood-vessels vaccination on a nœvus would be almost sure to cause a little bleeding, which would very likely prevent its success as far as vaccination was concerned, and even if it took it could only cure the nœvus by causing inflammation and sloughing. This might be only partially successful, and might even cause the rest of the growth to spread or multiply, therefore it is much wiser to treat the nœvus by excision or cauterising, and to perform the vaccination on some unaffected part of the body.

#### Royal Appointments.

MESSES. BRAND AND Co. ask us to announce that they have been honoured by the Royal Warrant of Appointment as Purveyors of Concentrated Beef Tea to His Majesty King Edward VII. The honour of being purveyors to H.R.H. the Prince of Wales was held by them for many years.

## THE DIAGNOSIS OF DIAPHRAGMATIC HERNIA. (a)

By E. FLETCHER INGALS, M.D.,  
Of Chicago.

THE diagnosis of diaphragmatic hernia presents many difficulties in the living subject; so great, indeed, are these, that the condition is seldom recognised until operation or death has yielded an ocular demonstration. The affection is found in rare cases at autopsies, and it is occasionally discovered in the dissecting room in bodies dead of other affections, but, all told, only a little over 300 cases have been reported. H. I. Bowditch reported a case in 1847, and at that time collected reports of eighty-eight cases. Leichtenstern (b) reported a case in 1874, and at that time collected reports of 250, but only five of these were diagnosed before death. Thoma (c) collected 290 cases in 1882 and many more have since been reported, but still the obstacles to diagnosis remain, although as shown by Leichtenstern, and by Abel (d) in 1894, there are some cases in which a reasonably positive diagnosis may be made without great difficulty. As I have elsewhere stated (e): "This affection possesses many symptoms and signs in common with pneumothorax, like which it causes distension of one side, displacement of the heart, diminished motion, tympanic resonance and feeble or suppressed respiration with metallic tinkling." The history will often be of the greatest aid in reaching an accurate conclusion. In the cases collected by Bowditch, twenty-six were congenital and the rest traumatic. The principal symptoms noted were dyspnoea on exertion and sometimes on lying down; pain in the bowels, especially after a full meal, in those where the opening through the diaphragm was small, and vomiting in several cases where the stomach was wholly or in part within the chest. In most of the cases the pulse was disturbed and in a few it was weak and rapid. In 27 per cent. of these cases the patients were in good health and engaged in active business.

In Abel's case the symptoms, which came on suddenly, were those of obstruction of the bowel, with vomiting, profound collapse, retraction of the abdomen and distension of the left side. He based his diagnosis upon the retraction of the abdomen, distension of the left side with tympanic resonance and displacement of the heart to the right, with the collapse, and absence of any passages either of gas or feces from the bowels. In his case it was impossible to introduce a stomach tube through the cardiac orifice; therefore this organ could not be irrigated. In Leichtenstern's case he was able to demonstrate the presence of stomach and intestines in the pleural cavity and to note changes in them from the introduction of water and air. This patient complained of dyspnoea on exercise, but worse during eating. There was slight cyanosis of lips, increased respiratory frequency, and almost an absence of heart dulness. Percussion and auscultation over front of thorax yielded normal signs. Heart sounds muffled and loudest at lower end of sternum. Abdomen flattened. Posterior part of thorax: slight loss of motion and prominence below the left shoulder blade. Percussion and auscultation normal to lower angle of left scapula. Below this a hollow, deep, tympanic note. In this region absence of vesicular breathing; instead of this, high-pitched metallic inspiration and expira-

tion, transmitted from the bronchial tubes, the inspiration loudest. Metallic tinkling and succussion sounds part of the time. The exact extent of area of metallic resonance and breath sounds was determined by auscultatory percussion. The borders where the metallic notes ceased abruptly varied considerably at different examinations. At times over the lower part of the chest the metallic breathing and quality of the percussion note would disappear entirely, and the resonance would merely appear exaggerated; at other times it would occupy a larger area and invade the axillary region and even send a tongue-like projection to the left border of the sternum. During percussion the pitch would run up and down the scale from deep to high notes, or the reverse. He believed this the result of peristalsis and emptying of the stomach or colon or filling of same with gas. At times percussion produced notes of varying pitch at different parts of the affected area indicating more than one cavity. At the lower part of the left and back of the thorax dulness would be noted at times. The border of this would change with changes in position of patient. (Contents of stomach.) He based his diagnosis on the following points: Percussion showed in the lower left side of thorax behind a hollow cavity that applied itself to the chest wall in a changeable area. It changes its position, shape, and volume in a very short time. The circumstance that at times metallic resonance was absent in the affected area while there was also absence of fremitus and vesicular breathing at all times over the area, showed that the cavity persisted, but the metallic resonance was lost because of filling of the cavity with contents or because of its contraction. When this contraction occurred the lung tissue and vesicular breathing encroached on the area of the cavity, the lung expanding and following it up. The shifting of the upper border of the area of dulness showed that the cavity contained at times movable contents, and the size of this area indicated the presence of the stomach. The different pitch of certain areas of metallic percussion that at times were separated from each other by areas of dulness was explained by the presence of more than one cavity. (Small intestine, colon, stomach.) The breath sounds over the area were either metallic or often absent. The respiratory sounds he thought were changed in quality and acquired a metallic character by transmission through smooth-walled cavities. The pitch of the metallic breathing was decidedly less intense than that heard in the pneumothorax, because the sound was not transmitted through the pleural cavity alone, but also through the gastric and intestinal walls. At times the metallic breathing was heard only with inspiration, whereas, in pneumothorax, on account of greater compression of the lung, the expiratory sound is the loudest. In addition, gurgling, either simple or metallic in quality was heard, also the metallic tinkling and splashing sounds, with bursting bubbles, trickling and pouring sounds, such as are heard in diarrhoea or ecstasis of the stomach. These sounds were at times very frequent, at other times absent. Leichtenstern argued that where similar sounds are heard in the normal thorax in the axillary and infra-scapular regions if the stethoscope is applied to the stomach or intestines, it can be readily shown that these sounds are far more intense in the normal situation of these organs, whereas in diaphragmatic hernia the dislocation of the intestines or stomach encourages the formation of peristaltic sounds through the place of communication of thorax and abdomen, and these sounds are louder by far in the thorax than they are when listened for over the abdomen. After old pleurisy with high location of the diaphragm the

(a) Read before the Chicago Laryngological and Climatological Association, May 2nd, 1901.

(b) Leichtenstern: *Berlin. Klin. Wochen.*, 1874, p. 497.

(c) Thoma: *Virchow's Archiv*, vol. lxxxviii., p. 515.

(d) Abel: *Berlin. Klin. Wochen.*, 1894, p. 84.

(e) "Dis. of Chest, Throat, and Nose," 1900, 4th Ed., p. 88.



stomach and intestines can occupy a high situation, but here we have a retracted and not distended thorax, with scoliosis, &c. Succussion sounds in this case showed the variable character belonging to all the other signs. When they were present they were deep, showing a large cavity. (Stomach.)

Almost all reported cases of diaphragmatic hernia show great variability in the signs.

Pneumothorax, the affection with which diaphragmatic hernia is likely to be confounded, results from pulmonary tuberculosis in 90 per cent. of all cases and in probably all of these is speedily followed by effusion of serum or pus into the pleural sac. The affection develops without the history of an injury. In the remaining 10 per cent. nearly all result from traumatism, and in most of these inflammation of the pleura speedily follows with effusion of fluid, though in a very few there may be no infection and the air may be absorbed without causing any effusion. In pneumothorax dyspnoea may come on suddenly or gradually, and we may often hear amphoric respiration, especially in expiration, which may be either intense or feeble, and which disappears when fluid rises high enough to cover the opening into the air passages. When fluid and air are present in the pleural cavity we may often hear metallic tinkling during the respiratory acts, and we may obtain distinct splashing sounds by shaking the patient's body while the ear is applied to the chest. The heart is constantly crowded to the opposite side, where it remains without variation. Diaphragmatic hernia is congenital or occurs through congenital defects in about 38 per cent. of the cases that have been recorded and in many of these it does not cause marked symptoms unless the hernia becomes strangulated. In about 60 per cent. of cases the affection is traumatic and therefore the history is quite different from that of pneumothorax. The dyspnoea in hernia may come on suddenly, and as suddenly subside, whereas, that of pneumothorax is more continuous. I have elsewhere stated that there is no amphoric respiration in diaphragmatic hernia, but the reverse of this is maintained by others. I cannot understand how typical amphoric respiration could be produced in diaphragmatic hernia, although I know that similar though more distant sounds, especially on inspiration, are sometimes heard. These, I believe, are caused by the transmission of the bronchial sounds through the intestines or stomach, some parts of which are distended by gas. The most important factors in the differentiation of non-strangulated cases are the following:—

1. The metallic tinkling in pneumo-hydrothorax and a similar sound, though different in quality, may be heard at times in diaphragmatic hernia. The quality of the sounds produced in the bowels and in the pleural cavity would often be sufficient to differentiate between them, but this quality cannot be accurately described; therefore the principal value of the sign depends upon the fact that in pneumo-hydrothorax it is heard only with respiratory movements or upon shaking the body, while with the hernia it occurs independently of these movements and is associated with rumbling or gurgling of gas in the stomach or bowels which have escaped into the pleura.

2. The displacement of the heart, which in pneumothorax remains practically constant, in diaphragmatic hernia may vary with the varying contents of the stomach or bowels, as when the patient is fasting or soon after eating or drinking freely. The retraction of the abdomen may prove of some value as a sign, and the symptoms of obstruction will be of the utmost importance if strangulation occurs. In a case saved by operation that was recently reported by E. W. Walker, there was the history of a severe injury, with symptoms of intestinal obstruction and

“diminished expansion of the left side of the chest, tympanitic resonance at the base of the left lung, amphoric breathing, succussion sound on shaking the patient and the apex of the heart was displaced two inches to the right.” In this case there had been a fracture of two ribs and the patient had some pain in the left side, which leads one to suspect a rupture of the lung with pneumothorax, in addition to the knuckle of bowel (involving eight inches of the gut) which was firmly held in the rent in the diaphragm. Walker cites numerous authors and states that among the symptoms named, dyspnoea, intense pain, and cough are the most prominent, and that typanitic resonance over the prolapsed gut, amphoric tinkling and sometimes succussion sounds are present.

The symptoms and signs must necessarily vary greatly according to the cause, the nature of the injury, when traumatic, and the condition of the organs protruding from the abdominal cavity. Larcher found that in about 91 per cent. of 275 cases no hernial sac existed. The signs would doubtless vary considerably in the cases in which the intestines protruded freely into the pleural cavity and in those where they were held down by the overlying pleura.

## THE CAUSE OF DIFFUSE PERITONITIS COMPLICATING APPENDICITIS AND ITS PREVENTION. (a)

By A. J. OCHSNER, M.D.,  
Of Chicago.

EVERY surgeon who treats patients suffering from acute appendicitis must be impressed with the fact that an unfavourable outcome in any given case means that the infection which was originally confined to the small space occupied by the vermiform appendix itself has first invaded the tissues immediately surrounding this organ and has been distributed over the entire peritoneal cavity. In other words, in fatal cases the patient practically always dies as the result of a diffuse peritonitis.

Other conditions may arise which may result in a fatal issue. There may be a septic thrombosis of the vessels in the vicinity of the appendix or an empyæma, or even pyæmia, but by far the greatest number of deaths occurs from diffuse peritonitis, and if it is possible to prevent this, the mortality from appendicitis must at once fall enormously. In order to plan a means for the prevention of this condition, it is well to study the progress of the disease from its onset.

There is danger of the occurrence of diffuse peritonitis in the following classes of cases:—(1) In gangrenous appendicitis; (2) in perforative appendicitis; (3) in cases in which the caecal end of the lumen of the appendix is closed and the distal portion so thoroughly distended with septic material as to make its walls permeable to micro-organisms; (4) in the very rare cases in which there are small abscesses in the walls of the appendix not directly connected with its lumen, and (5) in cases in which there is a septic thrombosis of some of the vessels, but not sufficient to cause gangrene.

The first, second, and third conditions are so common that every surgeon who operates frequently during the acute attack has seen them many times.

Were it possible to keep the septic material in these cases within the circumscribed area in which it

(a) Address delivered before the Section on Surgery and Anatomy, at the Fifty-second Annual Meeting of the A.M.A., at St. Paul, Minn., June 4th to 7th, 1901.

occurs primarily, it is plain that the condition would remain comparatively harmless.

The appendix is virtually surrounded on all sides excepting in the direction of the median line by relatively fixed tissues. Above we find the lower end of the cæcum and the cæcal end of the ileum; to the right and in front is the parietal peritoneum; behind the peritoneum covering the iliacus muscle, and towards the median line it is surrounded by loops of small intestines. Moreover, the omentum extends far beyond its lower end. It is true that the appendix may be displaced downwards, but in this case it will again be surrounded by fixed tissues which seem especially adapted to dispose of septic material. Again in this case there is an enteroptosis affecting the cæcum, and always with this a marked lowering of the transverse colon and stomach and with these the omentum. Thus we see that the natural anatomical arrangement for the protection of the general peritoneal cavity is extremely efficient. There is but one weak point in the anatomical provision for this protection, namely, in the direction of the median line, because the great mobility of the small intestines naturally favours the distribution of septic material to all parts of the peritoneal cavity. If we can prevent the small intestines from doing harm in this direction we will have accomplished our end, theoretically at least.

At this point I wish to direct your attention to another important anatomical condition. The blood supply of the omentum is so enormous that it will readily dispose of a very severe infection by walling off the surrounding structures if it is permitted to give its physiological attention to a single area. It is a well-known fact which every one who frequently operates during the acute attack of appendicitis has had many opportunities to observe, that the omentum crowds itself about any inflammatory or traumatic lesion within the peritoneal cavity the moment the latter occurs, and if left undisturbed, a few hours will suffice to cause efficient protective adhesions. These adhesions become stronger every hour and the blood supply in the omentum becomes greater, so that if no disturbance arises one can reasonably expect efficient protection to the general peritoneal cavity from the omentum.

Another important fact must not be lost sight of in this connection. The fact that the surrounding structures are relatively fixed in position favours the condition of rest of the inflamed part and permits the omentum to act after the manner of a splint applied to an inflamed joint. The value of rest as a preventive to the extension of an infection in any part of the body cannot be over-estimated. Consequently, if it is possible for us to secure this condition of rest we have gained another important point in the right direction.

In case the appendix is displaced upwards its position is even more favourable, because the available amount of omentum is thus increased. Again, if the appendix is retro-cæcal in its position, which is very frequently the case, the infection of the general peritoneal cavity is more easily prevented than when in its normal location. If anteriorly misplaced, it is likely to be fastened to the anterior abdominal wall by the adherent omentum.

It is plain, then, that the infection of the general peritoneal cavity must occur from a disturbance on the part of the small intestines, and must be due to their peristaltic motion. It is significant that in almost all cases of severe acute appendicitis the obstruction to the passage of gas and intestinal contents through the ileo-cæcal valve is one of the early symptoms. Nature is trying to prevent this very dangerous disturbance by closure of the ileo-cæcal valve. We have a condition corresponding to the contraction of the muscles surrounding an inflamed

joint, to the closure of the eyelids in conjunctivitis, &c. Moreover, the muscles overlying the appendix become tense. Everything tends toward the establishment of conditions of rest in the vicinity of the inflamed organ.

It is a fact which has been demonstrated a great number of times that peristalsis does not occur unless food or cathartics are introduced into the stomach. If the attack occurs shortly after a meal and before all of the food has passed through the ileo-cæcal valve, its presence may cause peristaltic motion in the small intestines. Upon reaching the ileo-cæcal valve the latter may prevent its passage into the cæcum, causing return peristalsis, and the intestinal contents are forced back into the stomach, whence it may be expelled by vomiting or be again forced into the small intestine, giving rise to further peristaltic motion. Moreover, it will give rise to the formation of gas, which must cause disturbance and pain in its attempt to pass the ileo-cæcal valve.

This motion, it is plain, will be harmful primarily from the fact that it gives rise to pain by disturbing the sensitive inflamed tissues; and secondarily from its likelihood of carrying infectious material with which it has come in contact in the vicinity of the inflamed appendix to other parts of the peritoneal cavity.

Besides this the physiological attention of the omentum can now no longer be directed to the single area of infection, because other parts of the peritoneal cavity require its protection, and such portions of the omentum as are not yet thoroughly adherent about the inflamed appendix are likely to be diverted from this point.

Theoretically, then, the disturbance which is to be feared to so great an extent is caused by the presence of food or cathartics in the stomach, and its logical remedy would be to absolutely prevent the introduction of any form of food or cathartics into the stomach and the removal by gastric lavage of any portion of food which may be retained in the stomach at the beginning of the attack. It may be necessary to perform gastric lavage twice or at most three times in order to entirely remove remnants of food which may have regurgitated into the stomach from the small intestines by reason of return peristalsis. That this is not only true theoretically, but also in practice, I have demonstrated in a large number of cases; and many other surgeons who have followed the same plan of treatment have informed me of the fact that their experience has agreed with mine.

It is true that a few surgeons have reported failures with this method, but an investigation of their treatment in each instance has shown that they disregarded one of the three cardinal points in the treatment. They either gave just a little liquid food by the mouth, or they gave some form of cathartics, or disturbed the rest of the intestines by giving large enemata, or they neglected removing the stomach contents by gastric lavage. Of course, the slightest amount of food is sufficient to start peristaltic motion of the small intestines, and the same is true of cathartics, and consequently if either of these features in the treatment is omitted one cannot hope for the same results. It does not matter what form of appendicitis may be present in any given case, it seems clear that this form of treatment must be useful, because in the milder cases it will result in rest of the affected part, and consequent rapid resolution; while in the severe cases it will guard against mechanical distribution of infectious material, and in all cases it reduces the tendency to meteorism and stops the pain.

There is, however, one class of patients in which I have found this treatment of the greatest value. I refer to the class in which the appendix is gangrenous

or perforated, and in which there is already a beginning general peritonitis. These patients give the impression of being extremely ill. There is complete obstruction to the passage of gas or feces. There is nausea or vomiting and marked meteorism; the pulse is small and quick; usually there is high fever, but the temperature may be subnormal; respiration is rapid, and the abdominal muscles overlying the appendix are tense. The patient is in a condition in which I formerly operated at once, day or night, as a last resort, only to find that it was too late in more than one-third of the number of cases, the mortality increasing with the time that had elapsed since the beginning of the attack. In this class of cases there is still a recovery of over 90 per cent. if the principles laid down above are thoroughly applied.

If peristalsis is absolutely inhibited, as it can be, the infection will soon become circumscribed and the pus can be evacuated with safety. Moreover, the condition I have just described is in itself the result of the administration of food and cathartics. Had these patients received neither food nor cathartics from the beginning of their attack, the condition would never have advanced to this dangerous point. This refers particularly to a class of cases which Richardson has so well described as "too late for an early and too early for a late operation."

If the plan I have outlined above is carried out, the following changes are likely to occur:—The nausea and vomiting will cease after one or two, or at the most three, gastric irrigations. The meteorism and the pain will decrease greatly during the first twelve hours, and will almost completely disappear in twenty-four hours. The pulse becomes slower and firmer and more regular, the breathing deeper, and the patient's general appearance improves to an astonishing extent. If the temperature was high, it will go below 100° F. the first twenty-four hours, and in three days it will be practically normal. The abdominal muscles will become soft as soon as the stomach contents have been removed by gastric lavage. Usually the improvement is so rapid that one is tempted to spoil everything by giving nourishment by mouth, because the patient's condition does not seem serious enough to warrant such severe measures.

That this form of treatment, which I have employed since 1892, at first only in selected cases, and later more and more generally, is really of great value is shown by clinical results. My mortality in cases of perforative or gangrenous appendicitis with beginning diffuse peritonitis is less than one-fourth as high as it was in the cases operated at once upon making the diagnosis, and even in advanced cases of diffuse peritonitis there has been a marked decrease in the mortality in my experience. It might be said that these cases were not due to perforated or gangrenous appendicitis, but that they were simply severe catarrhal cases, which are known to result favourably under any form of treatment. To this I would respond, that I have later removed the appendices in many of these cases, and have almost invariably demonstrated the correctness of the diagnosis.

In my statistics I utilise only the cases which I have operated in the Augustana Hospital, because of these I have full and accurate records, while of those operated in other hospitals and in private homes my records are not accurate, because there the patients and assistants are not so completely under my control. From Jan. 1st, 1898, to May 1st, 1901, I have operated in this hospital upon 565 appendicitis cases, which I have divided into three groups: 1, those who entered the hospital suffering from diffuse peritonitis; 2, those who entered the hospital suffering from gangrenous or perforative appendicitis, and 3, those who entered the hospital suffering from recur-

rent appendicitis in the interval between attacks or at the beginning of a recurrent attack when the infectious material was still confined to the appendix. Of the first class I treated 18 cases, with 10 deaths, 55.5 per cent. mortality; of the second class I operated 179 cases, with 9 deaths, 5 per cent. mortality; of the third class I operated 368 cases, with one death, 1.3 per cent. mortality. Total, 565 cases, with 20 deaths, 3.5 per cent. mortality. The statistics contain all patients who entered the hospital suffering from appendicitis; even those who died a few hours after admission.

Of Classes 2 and 3, all were operated, so there can be no doubt concerning their diagnosis. Of Class 1 all but 4 were operated, and these were in an absolutely hopeless condition when they entered the hospital. I will state also that during this time no patient suffering from appendicitis was refused admission into the hospital.

Judging from the authorities upon this subject, our mortality of 55.5 per cent. in diffuse peritonitis is as low as that recorded by any of the authors whose statistics contain a considerable number of these cases, while some authors with less than half this number report as low as 20 per cent. mortality. Krogus has compiled the statistics of fifty-eight authors whose combined mortality is a little over 70 per cent.

As compared with my own experience in former years, when all of these cases were treated surgically at once, my experience in this series of cases of diffuse peritonitis following appendicitis is quite encouraging.

It is in the second class, however, in which the greatest benefit from the treatment is found. In this class, according to most modern authorities, Murphy, Mynter, Porter, Lennander, Bull, and many others, there is a mortality of at least 20 per cent. This in my cases has been reduced to 5 per cent.; and had the treatment been instituted at the beginning of the attack, I am certain that the mortality could easily have been reduced to one-half of this. In Class 3 there should have been no death. Many of these cases had been treated through their acute attack by the method I have described, before being sent to the hospital. But as not all of the cases I treated outside of the hospital came later to operation, it is not fair to utilise these in demonstrating the value of the method.

Again, I have treated a large number of cases through the acute attack of appendicitis with this method which have never been operated, and which I have not included in my statistics, because the correctness of the diagnosis could not be established by actually demonstrating the condition present in the appendix.

However, the fact that there was a mortality of less than one-third per cent. in so large a number of cases is significant. It shows the value of a method by which cases of acute appendicitis in whom an operation is bound to give a high mortality at best, can be changed to chronic appendicitis in which the mortality following operation is almost nothing. It is, of course, not possible to come to any definite conclusions from a collection of statistics, because there are so many differences which can not be balanced.

Among these cases one is especially instructive because it illustrates the danger of operating too early. The patient entered the hospital five days after the beginning of the attack. His condition was exceedingly grave, as indicated in the history. With an immediate operation I should have expected his death within thirty-six hours. The diagnosis was made of gangrenous appendicitis. He was placed on exclusive rectal feeding. Within twenty-four hours his pain had entirely disappeared, his general

appearance improved greatly, the meteorism subsided, his temperature fell three degrees, his pulse came down forty beats per minute, his abdominal wall became soft, and twenty-four hours later I began to doubt my diagnosis. At the end of the fourth day his condition had improved so much that, upon his request, I concluded to operate, because he was normal in every respect with the exception of a slight induration in the region of the appendix and pain upon deep pressure. It seemed to me as though the process must have stopped just short of a perforation. Had he been left without an operation there could be no doubt but what he would recover temporarily from his attack. It seemed perfectly safe to operate. Upon opening the abdomen I found a perforated gangrenous appendix surrounded by a small abscess completely walled off by the omentum. I removed the appendix and the surrounding pus with great care, and drained the cavity, expecting the patient to recover, but a diffuse peritonitis developed, from which he died five days later. This case impresses the lesson that it is not wise to operate until the patient has fully recovered from the acute attack. Of course, he should be cautioned as regards his diet in order to prevent a recurrence, but I am confident that the mortality in my practice will be still smaller in the future, especially because I shall wait longer after the acute attack before removing the appendix.

The danger of rupture of a circumscribed abscess into the general peritoneal cavity has been the cause of great anxiety. My experience has led me to conclude that this practically never happens unless food or cathartics are given by the mouth. In my entire experience it has happened but once, in a child, *æt.* 7, which was brought to the hospital on the fifth day after the beginning of an attack of gangrenous appendicitis with beginning diffuse peritonitis. It had received food and cathartics constantly since the beginning of the attack, and although its condition seemed hopeless either with or without an operation, it improved slightly from day to day under exclusive rectal feeding, but never became well enough to make drainage of rather an extensive infection of the entire area between the umbilicus and pubis and right anterior superior spine of the ilium safe, and still, had I anticipated the likelihood of a rupture into the remaining portion of the peritoneal cavity, I should certainly have made the attempt with the hope of bringing about a recovery. On the fifth day the abscess suddenly ruptured. I anaesthetised the boy within half-an-hour, made a free incision, washed out the peritoneal cavity, drained freely, but the child died in six hours. In this case gastric lavage had not been employed because the child was very nervous and we feared the effects of the fright. I have frequently seen cases in which food and cathartics were given in whom this accident occurred.

Aside from the benefit to the patient of increased safety there are other advantages to be derived from this plan of treatment, which are well worth considering. Being able to operate during the quiescent state, drainage is not indicated, and consequently there is no likelihood of the occurrence of post-operative ventral hernia. With the reduction of the area of infection the amount of peritoneal adhesions must necessarily be reduced. As a matter of experience I can say that *fecal fistulae* almost never occur in cases treated by this method.

Of course, all these advantages, as well as the prevention of diffuse peritonitis, can be accomplished if the appendix is removed during the very beginning of the attack, before the infectious material has passed beyond the walls of the appendix, but unfortunately it is but very seldom that a patient enters the hands of a surgeon at so early a stage.

I am positive that the mortality would have been

at least four times as great had all my patients been operated at once, upon admission. There are three cases which do not properly belong in this group, because perforation had not actually taken place, but I am confident that this was only prevented by the treatment. Moreover, each one of these cases had quite advanced peritonitis at the time of admission, which would undoubtedly have progressed rapidly had not peristalsis been inhibited. In each of these cases the attack was exceedingly violent until this form of treatment was instituted, but subsided very promptly after commencement of this treatment.

*Conclusions.*—As a result of my clinical observations I am prepared to formulate the following conclusions:—

1. Peristaltic motion of the small intestines is the chief means of carrying the infection from the perforated or gangrenous appendix to the other portions of the peritoneum, changing a circumscribed into a general peritonitis.

2. This can be prevented by prohibiting the use of every kind of food and cathartics by mouth, and by employing gastric lavage in every case in which there are remnants of food in the stomach or in the intestines above the ileo-cæcal valve, as indicated by the presence of nausea, or vomiting, or meteorism.

3. The patient can be supported by the use of concentrated predigested food administered as enemata, not oftener than once in four hours, and not in larger quantities than four ounces at a time.

4. This form of treatment, when instituted early, will change the most violent and dangerous form of acute perforative or gangrenous appendicitis into a comparatively mild and harmless form.

5. Cases of perforative or gangrenous appendicitis, with beginning general peritonitis, can usually be carried through the acute attack safely with this method.

6. In all cases of this class gastric lavage should be practised in order to prevent the absorption of decomposing material from the alimentary canal.

7. In cases of doubtful diagnosis this form of treatment should always be employed.

8. This treatment will prevent a large proportion of the most troublesome complications and sequelæ of appendicitis, such as ventral hernia, *fecal fistulae*, extensive adhesions, &c.

9. The patient should be permitted to recover fully from his acute attack before an operation is performed, except in cases encountered within the first thirty-six hours after the beginning of an attack or in case of the formation of a superficial circumscribed abscess.

10. It often requires but a small amount of any kind of food to change a harmless circumscribed into a dangerous diffuse peritonitis.

11. The treatment does not protect the patient against a subsequent attack.

12. It does not contraindicate the removal of a diseased appendix before the septic material has extended beyond this organ.

13. It is indicated in all intra-abdominal conditions in which it is desirable to prevent the distribution of septic material by means of peristaltic motion.

14. The laity should be taught to stop feeding and giving cathartics to patients suffering from intra-abdominal diseases.

A FATAL case of small-pox is reported in Dundee. During the recent outbreak cases were for the most part of a mild type, and when the epidemic was at its height the city enjoyed a complete immunity from deaths. The first having now occurred, the other inmates of the dwelling have been removed to the reception house for observation,

## FEMORAL CYSTOCELE.

By Dr. RACOVICIANO,

Bucharest.

IN 1898 I had the honour to draw your attention to three cases of inguinal cystocele which I then presented to the Society. At the same time M. Aurin presented his paper on the subject, citing five cases which had occurred in one practice. I have said that in the records of medicine two cases of pure cystocele (a) are not to be found, the majority being cases of cysto-enterocele.

This complication of hernia is serious. To point out any characteristic signs of the bladder is difficult, owing to its physical state being so changed from the normal, and, in some cases, the vesical walls are torn during the earlier steps of the operation. Within my personal knowledge I can speak of two cases where the vesical walls were so thin as to tear, and were incapable of holding sutures, any attempt to secure which caused them to come through. This breakdown of the tissues was accompanied by a bleeding, which terminated fatally.

A case is published by M. Roux, and another by M. Flaquemont, in which a diverticulum of the bladder was mistaken for a hernial sac and resected. Mr. Feriger, of Chicago, cites seven cases in which he produced vesical fistulas, all of which did well. He considers the accident very common, not serious, one from which he has never seen a death. In my first case in 1894 I recollect a diverticulum of the bladder, which I mistook for a hernial sac, the viscus extracted, the ligature fell off, urine escaped into the fundus of the belly, and the patient died.

To-day I wish to bring under your notice a case of femoral cystocele complicating an irreducible enterocele. The patient, a servant, *æt.* 45, has been suffering for some time from an irreducible femoral hernia. He never complained of any bladder trouble, he passes his water in a full stream, and his prostate is but slightly increased in size. During the operation there appeared a second pouch which caused me to suspect the possibility of the bladder being engaged. To test this I now injected the bladder with fluid and passed in a sound, but without effect. I now enlarged the opening, replaced the suspected pouch in the belly, and again used the metallic sound which I now could readily feel with my finger through the vesical wall. By this manoeuvre I satisfied myself that the second pouch was the urinary bladder. These cases are rare. Jaboulais in Delbet's Pathology quotes the theses of De Legmud, which gives thirteen cases, and gives in detail two cases, one by himself and one by M. Aue, published in the *Centralblatt für Chirurgie*, which with our own makes sixteen cases in all. I do not know how many of these were women.

I consider this case important, and I think it right to report such complications as occur in hernias, inguinal and femoral, so that the risk of injury to the bladder by cutting or tearing may be avoided; for, as I have shown, such injuries are sometimes mortal. And, lastly, I may add that I have had the opinion that such a complication in inguinal hernia in women must be very unusual—indeed, I was sceptical as to its existence in woman, when on June 3th, 1899, operating on the woman, M.M., for an inguinal enterocele, I came on an inguinal cystocele. (*Bulletins et Mémoire de la Société de Chirurgie de Bucharest. Tome IV., No. 1.*)

(a) In this, M. Racoviciano is not accurate; there are more than two on record, the majority of which escaped notice during life, because pure cystocele is, as a rule, not painful.—Ed.

## Transactions of Societies.

## SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

THE provincial meeting of this society was held on June 29th at the Medical Institution, Liverpool,

Mr. ROBERT JONES, F.R.C.S., in the chair.

Clinical cases were demonstrated by the Chairman, Dr. Logan, Mr. R. W. Monsarrat, Dr. Macalister, Dr. Lloyd Roberts, Mr. W. Thelwall Thomas, Dr. James Barr, Dr. Stopford Taylor, Dr. Nathan Raw, and Mr. G. P. Newbolt.

Dr. HENRY ASHBY (Manchester) related a case of so-called fetal rickets. The mother was forty-six years of age, and the infant was her fourteenth, born at term, and well nourished. When seen at two weeks there was cranio-tabes, deformed chest walls, and five fractures, including both humeri, left radius, right ulna, and left femur. Three weeks later the right femur fractured. The infant eventually made a complete recovery. Dr. Ashby doubted if such cases were examples of true rickets, but rather resembled the osteoporosis produced by feeding puppies on food deficient in salts of lime.

Dr. RICHARD CATON (Liverpool) read a paper on

## THE TREATMENT OF ENDOCARDITIS,

based upon about 600 cases of that disease occurring in acute rheumatism and chorea. He advocated (a) absolute rest in bed for several weeks; (b) the application of a series of small blisters in the region of the first four dorsal nerves in front, followed by poulticing; and (c) the internal administration of sodium iodide. To be of service this treatment must be commenced within the first fortnight or so.

Dr. WILLIAM CARTER bore testimony to the great utility of the method.

Dr. A. ERNEST SANSOM thought blisters a little less than worthless in endocarditis.

Dr. C. I. MACALISTER advocated blistering and rest both in endocarditis and in pericarditis. Instead of a blister an ointment of the red iodide of mercury (1 in 8) might be employed.

Dr. JAMES BARR spoke of the good effects obtained from blisters in the treatment of acute rheumatism.

Dr. H. E. HUTTON testified to the rapid disappearance of pericarditis under blistering.

Dr. CATON, in reply, said that in acute rheumatism he used the salicylates along with small blisters to the joints.

Dr. GEORGE CARPENTER and Mr. SYDNEY STEPHENSON read a paper upon

## TUBERCULOSIS OF THE CHOROID,

based upon the examination of forty-nine cases of the kind. The lesions were found ophthalmoscopically in twenty-one out of forty-two cases of acute tuberculosis and tuberculous meningitis, or in exactly 50 per cent. In 119 cases of chronic tuberculosis, choroidal changes were discovered in no less than 9·2 per cent. In quiescent tubercle they were also found. The author described the characters of the choroidal tubercles, and pointed out the great diagnostic value of the growths. The communication was illustrated by microscopical preparations and by numerous paintings of diseased eyes.

Dr. A. ERNEST SANSOM and Dr. HENRY ASHBY discussed the paper.

Dr. WARRINGTON asked whether tubercles in the choroid were observed except in the last stage of illness.

Dr. GEORGE CARPENTER, in reply, said that in the acute cases mentioned in the paper tubercles were found in the choroid from one day to six weeks before death. Tubercle in the choroid did not necessarily warrant a grave prognosis, since some of the cases became obsolescent.

Dr. D. M. HUTTON (Southport) read a note on a case of

## SYPHILIS TRANSMITTED TO THE THIRD GENERATION.

The grandfather produced a certificate before his marriage certifying that having had syphilis he was cured.

The mother suffered from specific psoriasis. The child died of congenital syphilis at the age of five weeks.

Dr. HENRY ASHEY thought the infant might have succumbed not to syphilis but to a pseudo-syphilitic process of septic origin.

Dr. EDMUND CAUTLEY enquired whether there was any post-mortem evidence of syphilis in the infant.

Dr. GEO. A. SUTHERLAND could not accept the psoriasis present in the mother as pathognomonic of syphilis.

Dr. HUTTON, in reply, said the whole question resolved itself into one of possibilities and probabilities. Transmission in this case could not be demonstrated, but was highly probable.

Mr. R. W. MONSARRAT (Liverpool) read a note on two cases of

#### MENTINGITIS TREATED SURGICALLY BY DRAINAGE.

The results were fairly satisfactory. The choice of a route for drainage was discussed.

Dr. EDMUND CAUTLEY dwelt upon the initial difficulty of distinguishing between simple bacic and tuberculous meningitis. In his own cases the result of surgical interference had been uniformly unfavourable.

Dr. J. R. LOGAN mentioned a case of chronic hydrocephalus where the lateral ventricle had been drained, but the child died some months later.

Mr. DAMER HARRISON had passed chromicised gut into the lateral ventricles for the purpose of draining fluid into the base, but he was not inclined to proceed with the operation.

Mr. MONSARRAT, in reply, thought no operation satisfactory that did not combine ventricular drainage with drainage of the subarachnoid space.

Dr. JOHN H. BRYANT read notes of a case of pneumococcal peritonitis, which he had observed in a girl, *æt.* 4½ years. The abdomen was opened, general acute peritonitis was found, and pneumococci were demonstrated in the effusion. At the autopsy there was no pneumonia or pericarditis, but pleurisy and peritonitis were present. Dr. Bryant was inclined to think that so-called idiopathic peritonitis was of pneumococcal origin.

Dr. JAMES BARR discussed general infection with the pneumococcus as shown by pneumonia, pleurisy, peritonitis, and meningitis.

The following communications were taken as read:—

(1) Mr. E. Clement Lucas: "Removal of a Nail from the Second Portion of the Duodenum."

(2) Dr. John McCaw (Belfast): "Notes of a Case of Infantile Scurvy."

(3) Dr. C. J. Macalister (Liverpool): "Observations on Cirrhosis of the Liver and Endocarditis in Children."

(4) Dr. James Carmichael: "Bimanual Examination in the Diagnosis of Abdominal Disease in Children."

#### OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

MEETING HELD JULY 5TH, 1901.

The President, Mr. G. ANDERSON CRITCHETT, F.R.C.S., in the Chair.

Mr. SIMEON SNELL (Sheffield) related a case of

#### BLINDNESS RESULTING FROM SODIUM SALICYLATE.

The patient, a girl, suffered from acute articular rheumatism, for which sodium salicylate was prescribed. She woke from sleep at 7.30 a.m. and said that everything was dark in front of her. On the medical attendant's visit between 11 and 12 he found her unable to distinguish between light and dark. The next day Mr. Snell saw her and found her perfectly blind. The ophthalmoscope disclosed nothing abnormal in either fundus. The following day he again saw her, when she was succumbing to pericarditis with endocarditis. Again nothing abnormal in either fundus was detected. There was no return of vision, and she died that same evening. It was calculated that the total quantity of sodium salicylate taken must have been at least 140 grains in sixty hours. Mr. Snell said he thought that there could be very little question that the sodium salicylate was the cause of blindness in this instance.

Mr. J. B. LAWFORD reported a case of

#### MELANOTIC SARCOMA OF THE CONJUNCTIVA.

The patient, a woman, was shown at the Society in June, 1896. In July following two pinkish nodules appeared on the conjunctiva. A month later the cornea became hazy, and the intraocular tension raised. In October, 1896, the eyeball and conjunctiva were removed and were examined by Mr. Devereux Marshall, who reported the growth to be a pigmented sarcoma. The pinkish nodules consisted of connective tissue, cells, and blood-vessels. There was no growth whatever within the eyeball. In May, 1897, the patient had a serious illness with brain symptoms, and it was thought that an intracranial growth was present. However, she got better. In October, 1897, some new growth was seen in the orbit, and the general health was not good. On October 21st, 1897, the growth was removed, and was examined and found to be a sarcoma. In August, 1898, another recurrence was seen. On September 1st, 1898, the growth was removed and examined by Dr. Jenner and found to be a sarcoma. In April, 1899, another pigmented spot was seen, and in the following September another had appeared in the upper lid. On September 14th, 1899, the whole contents of the orbit were removed. On March 20th, 1900, the patient was very ill and died on April 23th, but no necropsy was obtained. Owing to the patient's very irregular attendance and also to her refusing operation in the early stage of the disease her chances of cure were much diminished.

Major H. HERBERT, I.M.S. (Bombay), described "Conjunctival Bridges and Pouches," due to union of retrotarsal folds, a condition found in nine upper lids of seven patients of all ages. One or more retrotarsal folds had contracted permanent adhesions with the tarsal conjunctiva evidently while displaced downwards through swelling in some previous inflammatory attack. The adhesions were sometimes multiple along the summit of the one fold; in other cases smaller adhesions of underlying folds were found beneath the principal ones. The folds had retracted, except when held by the adhesions, thus leaving the permanently displaced portions as broad or narrow bands, or bridges of conjunctiva connecting tarsus and fornix and freely admitting the passage of a probe beneath them. There was no history of injury in any case, but in the majority there was or had been trachoma. Two cases were also mentioned in which small bridges of union had formed between folds in the lower fornix. In another patient recovering from acute conjunctivitis (membranous or pseudo-membranous) the actual formation of these adhesions was seen. The union was primarily by means of fibrinous exudation, which apparently became organised. Finally, another upper lid was mentioned in which a broad fold came down over the tarsus and had adhesions not only at its summit but also over the greater part of its surface, leaving only a shallow pouch or pocket under each curved lateral margin.

Mr. SYDNEY STEPHENSON communicated notes of a case of

#### MILD SYMPATHETIC IRIDO-CYCLITIS

in a child fifty-four days after removal of an injured eye. The interval between the original injury and the enucleation of the eye was twenty days. The injured eye was affected with puro-plastic cyclitis, but micro-organisms could not be recognised. The patient when seen 16½ months after the accident had made a complete recovery.

The PRESIDENT referred to an observation of Liebricht that pressure on the nerve stump in the vacant orbit was painful in these cases.

Mr. DEVEREUX MARSHALL asked Mr. Stephenson if this was a record case. He himself had seen a mild case develop between two and three weeks after an eye had been removed for injury, but he had never seen a case develop so long as fifty-four days after enucleation.

Mr. SIMEON SNELL narrated a case of recovery of both eyes under similar circumstances. Enucleation sometimes sacrificed the better eye of the two.

Mr. STEPHENSON, in reply, said that he was not certain

what was the longest interval observed, but he did not think that his was the longest on record.

The following cases and card specimens were shown:—

Mr. C. Wray: Gumma of the Orbit which occurred forty years after Primary Syphilitic Infection.

Dr. W. C. Rockliffe: Cystic Growth of the Retina (probably Carcinoma) Secondary to a Primary Scirrhous of the Breast. There was evidence of both eyes being affected.

Mr. Marcus Gunn: Exceptional Appearance of a Choroidal Lesion, probably tuberculous.

Mr. Inglis Taylor: Peculiar form of Vitreous Opacity.

Mr. Harman: Hole in the Macula.

## France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, July 14th, 1901.

### PUERPERAL INFECTION.

At the Académie de Médecine M. Budin spoke on the treatment of puerperal infection as practiced by him for the last ten years. If fever set in, in a woman recently delivered, and that at the same time clots, fetid or not, were found in the uterus, interference might be limited to removal of the clots and washing out of the uterine cavity. But if the mucous membrane were found to be diseased, especially at the point of insertion of the placenta, the physician should not hesitate to practice curettage of the organ. Rapid improvement followed, provided that the operation was not retarded; but when the infection had lasted already several days a cure was effected more slowly, as the toxic germs had penetrated into the economy.

On the other hand, where the woman was delivered or had aborted several days after the rupture of the membranes, if the amniotic liquid were fetid, the same treatment applied.

### THE THERAPEUTICS OF LECITHINE.

M. Lancereaux treated the question of the employment of lecithine in therapeutics. Recent researches have proved that lecithine plays an important rôle in the nutrition of the organism in general, and the nervous system in particular. Several experiments have confirmed this fact, and have demonstrated, moreover, an increase of weight of the animal or of man under the influence of the agent. Professor Lancereaux instanced the cases of two patients in his wards who were suffering from pancreatic diabetes arrived at an advanced stage, and who wasted away in spite of every effort to prevent the emaciation. Under the influence of lecithine not only did the wasting cease but the patients gained rapidly in weight and at the same time their general condition was improved.

These results prove the great value of lecithine as a stimulant of nutrition. Not only does it arrest the rapid denutrition of diabetic patients which generally nothing arrests and leads to phthisis, but it increases their weight, restoring to them their strength, and, to a certain degree, their buoyant spirits.

He also employed lecithine in several other cases, in persons suffering from different affections accompanied by denutrition, and the results were always the same, an increase in the weight and a rapid progression of strength. A young man suffering from osseous tuberculosis with amyloid kidneys and abundant albuminuria, was given six grains daily of lecithine for fifteen days; his weight increased by six pounds. A child,

set 10, extremely thin and ill-nourished, with coughing and hectic fever every evening, was ordered four grains of lecithine daily; at the end of a month he had gained four pounds in weight, while the general condition was notably improved. A little girl, set 8, ill with bronchopneumonia and in a very wasted condition was given the same dose of lecithine for a month with similar results. Other examples might be cited, but these are sufficient to establish the excellent effects of lecithine in all cases of rapid denutrition.

## Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, July 13th, 1901.

At the Society fur Innere Medizin, among those who took part in the discussion on

### TUBERCULOSIS

were A. Fraenkel and v. Leyden. The former said that he had made extensive investigation into the presence of bacteria in the blood, and it was indubitable that the presence of bacteria in living blood was not incompatible with maintenance of life for lengthened periods. The pneumococcus had been observed in blood for six months. The speaker would not deny mixed infection, but he would not ascribe every possible thing to this origin, and especially failures in treatment. The fever was not always due to it; tuberculin inoculation showed that. In a recent investigation in the last stage of the disease in a patient no bacteria were found in the blood. How could they attribute the hectic fever to this vanishing quantity of germs? It was undoubtedly the product of the toxins formed in the cavities. The significance of germs in the blood depended on their numbers. In fibrinous pneumonia the pneumococcus only was constantly found. If present in large quantities it might be taken that death would result from sepsis or that metastases would form, but with a small number of germs their presence was of no importance. The majority of these patients got well, whilst experiments on animals proved that the bacteria were virulent.

Hr. v. Leyden said that Hr. Kaminer had brought forward an important practical question, one, moreover, that could not be solved at once. He had long been interested in the subject of the artificial interruption of pregnancy. In 1891 he had discussed the question of pregnancy and heart disease, as to whether artificially induced abortion should be performed. Gynecologists had espoused different views as to his proposals. Gussnerow had at first opposed them, but later on had conceded that in bad cases of cardiac disease the pregnancy should be interrupted. In connection with his work he had suggested artificial abortion in renal disease and phthisis. In his view the question should be decided on its merits in respect of each case, and not on general lines. The old belief that tuberculosis came to a standstill during pregnancy, and got rapidly worse after delivery, could not be retained, one could not see how pregnancy could be a protection against tuberculosis. Formerly it was a custom to starve lying-in women for a week after delivery, and this perhaps contributed to the more rapid decline, much would depend on the state of the woman, and if she was living in great misery she should be freed from her burden. In any case the physician had the right of interrupting a pregnancy, a right which formerly, in view of the destruction of infant life, had not been con-

ceded. Another question was, should the physician dissuade tuberculous people from marrying. Here also no distinct principle could be laid down, as the transference of the disease to the embryo not having been decisively proved.

At the Berlin Medical Society Hr. Herzfeld showed a  
CASE OF RECOVERY AFTER ABSCESS IN THE LEFT  
FRONTAL LOBE

in a young man, *æt.* 20. The patient came to the Klinik on May 15th; he had nasal catarrh first on the right and then for three weeks on the left side, then he had severe left frontal headache of a malarial type. Examination showed swelling of the mucous covering of the turbinated bones, copious purulent discharge, high temperature (40 C.), and slow pulse, 86 at first, later 50. The speaker, from the character of the pulse, concluded that intracranial disease was present. On May 22nd he trepanned the left frontal sinus, this contained much pus and granulations. The posterior wall of the sinus was carious, and could be penetrated with a probe. This was removed when the dura mater projected. No pus appeared at first. Then a piece of frontal bone was opened, the dura mater split, when a large quantity of pus escaped from the sub-dural space. A small fistula led into the abscess cavity proper. This was enlarged until the finger could be passed in. The result was favourable. The rather large intra-dural and intra-cerebral abscess had caused absolutely no other symptoms than those named. The intelligence had in no way suffered except for slight weakness of thought.

Hr. Gluck showed four children with

RECURRING TUBERCULOUS PERITONITIS, in which puncture, laparotomy, &c., had been performed without success. Recovery was brought about by leaving the abdomen open, on several occasions in two sittings he had opened it widely, with a transverse incision added, and had removed the tuberculous mass partly with the blunt spoon, had resected the omentum, and packed the abdominal cavity. The duration of the recovery after the operation had been from four to one and a-half years. During the after treatment one could watch the caseous masses gradually disappearing, to be first followed by fungous granulations and cicatrisation.

The *Deut. Med. Zeit.*, 53/01, relates a case of

TRIPLET ABORTION IN TWO STAGES.

A woman, *æt.* 30, after two months suppression, had hæmorrhage, and was delivered of a two months' fetus. Three months later she again complained of pain, and stated that the abdomen had continued to enlarge after the last abortion, and that the menses had not returned. On examination a pregnancy of four or five months was diagnosed. Soon after this, on lifting a heavy weight, bleeding came on again, and two living fetuses, both males, were expelled, one being 24 *ctm.* in length, the second 21 *ctm.* They had a common placenta.

## Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, July 13th, 1901.

CECHISCH CONGRESS.

THIS is the third Congress held under the auspices of

this body, although it has been in existence for the last twenty years. Its object is the furtherance of medicine and allied physics among the Cechs and Slavs whose language is official. It is now nineteen years since the last Congress was held, which is a very unusual interval. On that occasion the inauguration took place of a Cechisch University at Prague, which is now a flourishing rival to the German seat of learning in the same city. The numbers present at the Prague meeting are computed at 1,000, while the XII. sections had 360 papers read of a national interest. It was suggested as an explanation that the last time they met, it was to obtain a charter for a University; on the present occasion a second University is proposed on account of the rapid increase of students at the first. The second University will be for Moravia, with the native language, which they consider is more conducive to education and scientific investigation, the promoters pointing to Holland and Sweden for examples.

Prof. Thomayer opened the proceedings with an exhaustive paper on "The Influence of Civilisation on the Nerve System." He treated the subject in a manner that proved that civilisation was not injurious to the nerve system, but rather favoured its preservation. On the last day Prof. Bayman gave a very interesting address on the advance of chemistry and its influence on physics.

The next Congress is fixed for 1906 in the same city.

### MYELITIS CHRONICA.

At the Bohemian Society of Medicine Prochazka exhibited two cases of a neurotic order. The first was that of a young man, *æt.* 29, a porcelain painter, who complained of general weakness in the lower extremities which had commenced about five years ago, otherwise he was fairly well. On examination the objective symptoms were distinctly marked paresis of the lower extremities, pyretic movement, and distinctly spæstic symptoms. There were well-marked muscular tonus, forcible resistance to passive movements, increased patellar reflex, shortening of the Achillis tendon, and pes equinus of the feet. Sensibility was normal, bowels regular, but the function of the bladder was disturbed as the feeling of micturition brought about instant attention, the patient having no power to retain his urine. The upper extremities had the triceps reflex increased. There was no history of syphilis, chronic hydrocephalus, or cerebral diplegia, as no cerebral symptoms were present. The bladder disturbance seemed to be the only differential point between multiple sclerosis and chronic myelitis, which is common in the latter.

The second case was that of a man, *æt.* 30, who for twelve years past had suffered from a distinct weakness in the lower extremities, which he observed in springing or jumping. A similar sensation was also present in the hands. The leg weakness had increased within the last four years more rapidly, he having to assist himself with a stick in locomotion. The first symptom of pain appeared two years ago in the form of cramp while shooting or undressing. For the last ten years the hands had got thinner and the muscular tissue wasted. The object of examination pointed to hydrocephalus nystactiform contractions, atrophy of both optic nerves, atrophy of the muscles of the hands of the Aran-Duchenne type, atrophy of the muscles of the lower limbs, analgesia over the whole trunk,



thermo-hyperæsthesia in the extremities, although the patient is able to tell the difference between hot and cold water, he is unable to distinguish smaller differences of temperature. There were also spastic symptoms present, with exalted muscular tonus, cramping in the quadriceps cruris when active movement was produced, as well as fibrillary contractions in the upper limbs.

Proczakka diagnosed disseminated sclerosis in this case. Syringo-mylitis was negatived by the long duration (sixteen to eighteen years) of the disease, the temperature sensation, and the absence of trophic disturbances. Amyotrophic lateral sclerosis was also negatived by the protracted duration of the disease.

#### BLOOD PRESSURE IN FEVERS.

Federn read an exhaustive paper on blood pressure to the "Gesellschaft," which has much interest for the medical practitioner in the application of drugs. Scarlatina, cholera, and malaria, as he has told us before, have always a high blood pressure, and in scarlatina the higher the pressure the more severe the attack, probably owing to the early cardiac hypertrophy not being maintained.

On the other hand, influenza can be diagnosed by the low blood pressure being 50 to 60 mm. of mercury, or 1.9 to 2.36 inches. Eight years ago he pointed this out from the intestinal symptom which seemed to point to dilatation of the vessels of the bowel. The only other disease that might be confounded with this low pressure is icterus, which may be differentiated by the colour of the skin, conjunctiva, &c.

In the recent epidemics of influenza, antipyrin, phenacetin, salipyrin, &c., were used as specifics, which looks rather anomalous when we consider that it relieves the pain in febrile or non-febrile conditions, and that these drugs are supposed to act through their depression of the arterial system. The curative action of these drugs in influenza rests on the physiological fact that they dilate the small arterial vessels, which are greatly constricted by the influenzal toxin, and thus diminish the resistance to the cardiac efforts, which are also weakened by the toxin. The first effect of the influenzal poison is expended on the heart and vascular circulation, giving rise to a multiplicity of symptoms such as fatigue, headache, &c., and according to the severity or otherwise of the hæmatic symptom some patients suffer from a variety of symptoms not met with in others, such as brain affections, others from muscular troubles, while a third may have only a bowel lesion.

The primary cause is the toxin, as the simple interference with the cardiac movement would not so affect the muscles, while the slow recovery from the bradycardia, often lasting a year, confirms this opinion.

The prognosis in disease can also be gauged by the blood pressure with approximate accuracy. In diseases of high pressure the danger is greatest in elderly people, and when not fatal may so irritate the vasomotor centres as to produce arterio-sclerosis. It has been affirmed that the opposite condition produces calcification of the vessels, but this is incorrect, although normal blood pressure not infrequently produces arterio-sclerosis.

The treatment of influenza is correctly carried out with antineuralgics and antipyretics in order to relieve the blood pressure. Purgatives also relieve the atony of the bowel.

Eisenschnitz thought the influenza poison damaged

more than the heart, and opined to show that it was a case of general intoxication.

Teleky objected to antineuralgics as specifics in influenza, and doubted very much the action ascribed to the heart.

Winternitz asked if the blood pressure remained low throughout the disease, or was it altered in the event of croupous pneumonia appearing. As to arterio-sclerosis, he always understood this to be associated with high pressure, which so paralysed the vascular system as to induce the sclerosis.

## The Operating Theatres.

### MIDDLESEX HOSPITAL.

#### LAPAROTOMY FOR PERITONITIS OF DOUBTFUL ORIGIN.

—Mr. JOHN MURRAY operated on a man, æt. 33, a cab driver, who had been admitted for abdominal pain. The man had had good health all his life, but he stated he had suffered from indigestion. A fortnight before admission he began to complain of pain across the lower part of the abdomen. The pain was of a gripping character, and he was unable to account for it in any way. It got worse, and he was obliged to take to bed. He felt very weak, had no appetite, and during the attacks of pain he could feel a lump in the left iliac region about the size of a walnut; the abdomen was very tender and deep inspiration caused pain. His bowels were confined, and he had great difficulty in passing very scanty motions. He was ordered an enema, which produced a good evacuation, and he passed a large quantity of flatus. The day before admission he vomited once, the vomited matter being white in colour and frothy. The pain commenced always on the left side of the abdomen. On admission at 10 p.m. he was a well-nourished man with a great deal of tenderness in the abdomen. He lay on his back, the face was pale, he was not collapsed, the skin was moist; the abdomen was slightly distended, the abdominal wall rigid, and respiratory movements were limited to the upper part. The abdomen was resonant except in the left iliac region, where there was marked dulness extending into the left flank; liver dulness was normal; there was resonance in the right iliac region, and nothing abnormal could be felt on deep palpation. There was marked tenderness over the whole of the abdomen, especially in the left iliac region, where an increased sense of resistance was distinctly felt. The temperature was normal, pulse 98, the tongue was moist and thickly coated with white fur. Examination per rectum the bowel was found to contain some hard fæcal matter, but nothing abnormal could be felt either in the rectum or in the pelvis. On the following day the patient's condition was worse, the pain and tenderness were more marked, the rigidity of the abdominal wall more pronounced, the man had vomited once, the vomited matter being greenish in colour. The bowels had not acted satisfactorily, though he had been ordered an enema only a few scybalous masses came away; pulse was 112, temperature 101°. It was decided to open the abdomen, the patient's condition being obviously serious. An incision was made in the middle line below the umbilicus. On opening the peritoneum a quantity of stinking, purulent fluid escaped; the intestines were everywhere

adherent and covered with numerous flakes of thick yellow lymph. The abdominal cavity was flushed out with sterilised water at temperature of 110°, and an attempt was made to find the source of infection. The cæcum and appendix were found to be normal; in the left lumbar and iliac regions there was a large, hard mass consisting of matted coils of intestine, and on separating some of these adherent coils a large collection of exceedingly fetid pus was evacuated from the left iliac fossa. At this stage of the operation the patient stopped breathing, but soon recovered on artificial respiration being performed. As it was not considered desirable to further investigate the cause of the trouble, the abdomen was mopped out, a glass drainage tube inserted into the pelvis, and the wound closed with silk-worm gut sutures passed through the whole thickness of the abdominal wall. Mr. Murray said that the interest of the case lay in the diagnosis, which was rendered difficult on account of the impossibility of obtaining anything like a complete history from the patient. When seen shortly after admission, he (Mr. Murray) was of opinion that the case was not one of peritonitis, and was rather inclined to regard the symptoms as due to chronic intestinal obstruction; the general appearance of the patient and the normal temperature rather strengthened this view. The pain was of distinctly colicky character, and during attacks the patient was seen to raise himself in bed on his hands and knees, which was thought not likely to occur in peritonitis. The case had none of the features of an ordinary one of appendicitis; if the patient's statements were to be relied on his symptoms commenced and for some time were limited to the left side of the abdomen, and the tenderness was less marked on the right side, and there was nothing to be felt in the region of the cæcum. There was no history of injury such as might point to a rupture of the intestine, and although the man complained of attacks of indigestion, there was nothing to indicate perforation of a gastric or duodenal ulcer. Operation was therefore postponed, the patient being ordered an enema and a hypodermic injection of morphia. On the following day there could be no doubt that the patient had general peritonitis, though there was nothing to indicate the cause of the condition; therefore it was decided to operate at once. The abdomen was opened in the middle line, as it afforded the best position for exploring all parts. All that could be determined at the operation was that the origin of the infection lay in the matted coils of intestine on the left side the exact nature of which was purely speculative, though Mr. Murray thought that it might be accounted for by some slight injury which had produced rupture of the intestine, which had escaped the patient's recollection, or that it was secondary to ulceration of the intestine with perforation. He pointed out that from the condition found at the operation it obviously would have been better to have opened the abdomen the night before, though it would not have made any difference to the ultimate result, as the extensive adhesions present showed that the peritonitis was at all events of some days' duration, if not dating back from the commencement of the illness a fortnight before, and such a condition he considered absolutely hopeless.

The patient died twenty-four hours after the operation. At the post-mortem an annular growth of the

upper part of the rectum was found giving rise to considerable stricture, with ulceration and perforation at seat of growth; there was general peritonitis. The glands of the mesentery in the region of the growth were infiltrated, otherwise there were no secondary deposits.

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## The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, JULY 17, 1901.

### LORD ROSEBERY ON A NOBLE PROFESSION.

It would be hard to find a more fitting orator than Lord Rosebery for any festival requiring cheery wit and a philosophic knowledge of men and things. Last week he occupied the chair at the twenty-eighth festival of the Royal Medical Benevolent College at Epsom, of which institution he is President. The college is one of the few organisations in existence for the benefit of the families of deceased medical men. Its present position was tersely described by Lord Rosebery when he stated that there were fifty foundation scholars, chiefly necessitous orphans of medical men, and the fixed income of the institution was not more than one-third of the £6,000 which had to be raised for its maintenance. It is gratifying to be able to announce that the result of the appeal made by the noble chairman resulted in subscriptions and donations to the extent of £4,127. The mere fact of the necessity of such a step implies that the members of the medical profession have not extended to Epsom College that measure of support which it deserves at their hands. The well-to-do medical men in the United Kingdom could readily support the Epsom foundation in affluence by an individually small contribution. It is a melancholy fact that the conditions of practice in this country are such that in many cases the medical practitioner is unable to make any provision for his wife and family. Should he die before the children are grown up and equipped to take their part in the battle of

life their lot is often of the hardest. The Chairman summed up the position in a few terse and eloquent sentences when he remarked that it was easy in an assembly like that he was addressing to fancy that the medical profession was nothing but a brilliant and a lucrative one, but when one came to think that there were some thousands of medical graduates turned out every year—that there were some 30,000 in the United Kingdom—one could not feel but that the number of blanks in that profession must be out of all proportion to the prizes. The princes and the prizemen formed only a small proportion of the great number in the country, and of the small practitioners in the towns who are at the beck and call of disease and suffering by day and by night, in every weather and at every hour. It was a noble profession, but in many cases it was a profession of forlorn hopes. The truth of that presentment must be at once endorsed by all who know the inner life of the medical world. The interests of the medical profession are at the mercy of unfair competition on all sides. Perhaps when Lord Rosebery returns to Office in the Government, as one day he assuredly will, he may remember the sad case of the medical profession and help forward some saving legislation on its behalf. An amended Medical Act is wanted as an initial step whereby quack practice might be readily and efficiently repressed; the patent medicine stamp should be abolished; but, above all things, a General Medical Council should be constituted upon a basis really representative of the rank and file of the medical profession, and its powers should be extended so as to include the power of protecting the public as well as the profession from illegal practice. In that way Lord Rosebery might do much to relieve the forlorn hopes of what he has kindly spoken of as “one of the noblest, if not the noblest, of all the professions.” It is to be hoped that the hurry and rush of political life, especially for those who are weighted by the responsibility of office, will not obliterate or overwhelm the convictions that were stated by him with so much eloquence at the recent festival. As everyone knows, it is one thing to give utterance at a public dinner to abstract and general admissions of the existence of an undesirable state of affairs, but quite another thing to undertake the task of practical reform. It seems hardly possible to imagine that the Medical Acts will remain untouched when Parliament finds time to turn to the many social matters that demand earnest attention. Meantime it is the duty of the medical profession to proclaim its wants with clearness and steady insistence, and to urge that the public speeches of statesmen may be backed up with legislative performance.

#### THE CASH VALUE OF A FINGER.

A PROVISION merchant by ill-chance happened to scratch the second finger of his right hand on a nail projecting from some part of a haddock box. On April 14th, 1900, he consulted his private medical

attendant, in Leith, five days after the accident. The physician *prescribed* (according to reports of the case) for him. On May 18th the digit had to be amputated; *i.e.*, thirty-nine days after the scratch. The merchant then claimed £500 damages from his physician for professional negligence. The judge who first heard the case in the Lower Court dismissed the action, but on appeal the Higher Court decided that there were grounds for it going to trial. Before this, however, the defendant settled the case by payment of £100 and expenses. As reported the important facts in the case *non sunt*. The doctor explained that his work after his first interview with the pursuer had had to be delegated to another physician, owing to his own ill-health. No note is given of how the pursuer acted up to instructions, if he committed indiscretions, &c. An instance of personal application might well be noticed here. The writer was summoned to a club official, the greater part of the top of whose left index finger hung by only a narrow band of skin to the proximal portion of the digit; the nail crushed and crumpled, but the terminal phalangeal bone only bruised, not broken. These injuries were due to a crush between a door and its jamb. The detached portion was pulseless, insensible, bloodless; the terminal phalanx devoid of periosteum over a part of its surface. The method of treatment followed consisted in trusting to nature. The various bits brought together after their surfaces had been “dabbed” only with 1:40 carbolic, covered with protective, protected with dry antiseptic cotton wool in excess, and the hand and arm supported by a sling. The questions at issue were mainly: “Is it possible to preserve the vitality of the bruised and torn fragments? Which is of greater importance: Rendering the wound aseptic, or endangering the vitality of the half-separated portions by the use of antiseptic agents?” Now, if this incomplete and theoretically inefficient cleansing of the wound had been followed by septic conditions, the judgment of the exponents of legal empiricism would probably go against the adviser of such a plan of treatment. If successful, as was the case just mentioned, no fault would be found although the measures adopted in each event were the same. It is most common to meet with instances among doctors in which a finger, or part thereof, has had to be amputated owing to their too faithful adherence to antiseptic rules, to the death of tissue caused by too forcible bactericidal measures, and ignorance of the fact that antiseptic agents employed in even slightly too concentrated a form may kill more than bacteria, and result in more harm than benefit. Each case of crushed or poisoned fingers or toes differs in character and detail. The result in such cases physicians or surgeons must needs strive for, consists in the attempt to save tissue. If vitality be so low that the action of antiseptics will possibly destroy the diseased or injured part, trusting to nature may be quite successful. Should this fail, the

end is one and the same—the knife. How, then, can anyone judge, especially in the absence of emergency, the motives which may lead to the adoption of one of two courses, when it is apparent that either of them may fail, either may succeed, either seem to be unsuitable, or either to be warranted? Cases belonging to this category usually impose most unmerited hardships upon medical men. How can they explain that they prefer expectant methods, and have obtained good results from them, to the more official, up-to-date measures, in dealing with certain cases? This argument is logical, full of common sense; the chances of continuance of vitality in severely affected tissues, when reliance is chiefly placed upon the recuperative powers of nature, are often better than after a routine application of antiseptics from a too conscientious regard for the fashionable usages of the day.

#### NEW DEPARTURE IN PENALISING THE PROFESSION.

SIR FORTESCUE FLANNERY, M.P., has the reputation of being a level-headed and capable man of business. What Nemesis, then, can have driven him to bring forward the fresh clause of which he has given notice as an amendment to the Factory and Workshop Acts Amendment Bill, now being discussed by the Standing Committee on Trade of the House of Commons? We cannot persuade ourselves that Sir Fortescue Flannery could have drafted the clause himself. For not only is it utterly objectionable in principle and design, but it betrays such crass ignorance in every line, and is withal so entirely unworkable, that we can only imagine the clause was drafted by some illiterate and ignorant persons, and that they in an evil hour have been able to exercise pressure to induce Sir Fortescue to adopt it without his having even read it. The clause in question is another of those unjust inroads on the personal liberty of medical men whereby government by special penal legislation exacts the fruits of their scientific knowledge and experience. Such forced labour is indistinguishable from slavery, and whether paid for or not is utterly objectionable and unjustifiable. In this case Sir F. Flannery does not even propose to gild the chains of the forced labourers, and he proposes not even the noble half-crown for the important services which, in his ignorance of the subject, he hopes to compel medical men to render to the public. It may not be inopportune to ask whether he allows the Government to compel him to give information on special engineering subjects to the public, and if he is content to do such work for nothing? By his proposed new clause he would compel medical men, attending a case of "anthrax (suspected)," to take some of "the serum" from the patient, whether the latter or his friends are willing or not, and to send it to "a bacteriological expert" for microscopical examination; and in case of the death of the patient some person or other, for

no one is specified, is to take "the serum" from the dead body and forward it to the same destination. It is somewhat amusing to note that what "the serum" means is not indicated. It is well to be outspoken on such a matter. To us the proposal is nothing short of an outrage on the patient and his friends, to say nothing of the medical attendant who may consider the proceeding would seriously affect a prostrate sufferer from anthrax, for we know well the alarm with which most persons, especially the poor and ignorant, regard anything which their imagination suggests is in the nature of what they all term "an operation." Is the doctor to be compelled to waste the flickering energy of his prostrate and dying patient by arguments directed to prove the painlessness and harmlessness of the proceeding, and the benefit to science, and the evidence which it may afford in legal proceedings against an employer? Even if the doctor thought the agitation of this proceeding might injure or kill his patient, under Sir F. Flannery's clause he must persist in drawing the serum. The idea is repulsive in the extreme. It is more cruel than the most reckless experiment in vivisection, and it is not certain that the medical attendant would not be liable for cruelty were he to carry out such a heartless and unjustifiable experiment, and the offensive proposal has not even the recommendation that it is intended for the relief of the sufferer. He would receive no benefit from it whatever. When we add that even if the medical attendant succeeded in overcoming the objections of the friends and the patient, the whole heartless proceeding would in most cases be utterly useless, we shall have completed the indictment against this most unjustifiable proposal. Now, it is well known to all persons acquainted with the subject, but obviously not to Sir F. Flannery, M.P., though he represents a district where anthrax is familiar, that the bacilli are very rarely indeed to be found in the blood in the early stage of anthrax, by microscopical examination, even when the presence of the virus can be demonstrated by inoculation. The negative result would tend to seriously confuse the diagnosis in the opinion of many persons. The action of Sir F. Flannery, M.P., in persisting in putting forward this proposal is greatly aggravated by the fact that the Home Office refused to act on the suggestion to insert the clause in the Bill, on the irresistible ground that existing powers are quite sufficient to enable all necessary information about such cases to be obtained. We trust the whole profession, and all reasonable men will rise against this indefensible proposal to impose fresh penal legislation on medical men, and to compel them to inflict unjustifiable hardship, pain, and cruelty on their patients. The following is the text of the proposed clause, and never did so few words construct such a monument of ignorance and folly.

*Sir Fortescue Flannery's Proposed New Clause in the Factory and Workshop Acts Amendment Bill.*

"With every notification by a doctor (1) or other

interested person of a case of anthrax (suspected) <sup>(2)</sup> poisoning, the medical practitioner attending <sup>(3)</sup> the patient shall immediately forward a specimen of the serum <sup>(4)</sup> to a bacteriological expert appointed by the Secretary of State for microscopical examination <sup>(5)</sup>, and in each fatal case of anthrax a specimen of the serum taken <sup>(6)</sup> as soon as possible after death, shall also be forwarded to such expert by the doctor who certifies the death." <sup>(7)</sup>

The following points are deserving of attention:—

(1) Doctor of what? Music, laws?

(2) Merely "suspected" cases are not notified.

(3) If some "other interested person" has sent away the notification without informing the doctor, how can the latter be compelled to send the serum along with it?

(4) What serum? Who is to take "the serum"? There must be no blood with "the serum"!

(5) Such microscopical examination in early stages usually gives a negative result, and this may lead to a denial of the case being anthrax.

(6) Taken by whom? Who has authority to forcibly make such a post-mortem examination?

(7) What is to happen when the bacteriological expert has made his microscopical examination? To whom is he to report his results?

(8) Inquests are usually held on fatal cases of anthrax. Interference with the body before the inquest would cause serious difficulties with the coroner.

## Notes on Current Topics.

### Cocainisation of the Spinal Cord.

At the meeting of the "Société de Biologie," on the 25th ultimo, a very interesting discussion on the action of cocaine as anæsthetic and the best method of cocainisation of the spinal cord took place. To exhibit the constricting power of the drug M. Laborde exhibited a rabbit, the sympathetic nerves of whose ears he had cut. The vessels of the ears became enormously engorged, and then he hypodermically injected five milligrammes of cocaine into the base of the ear, which quickly became exsanguine. This effect M. Laborde considers is not wholly due to the effect of the cocaine on the muscle tissue, but is due in great part to its effect on the nervous tissue. And he considers that the direct action of the drug on nervous tissue is a great source of danger, and quotes the case of a woman in whom a carelessly-given interspinal injection produced dangerous effects from coming in contact with the nerve tissue. For the intra-medullary injection he proposes an extra-dural one, where absorption is very rapid. Indeed, he found that intermuscular injection was in many cases equally useful. He gave hypodermic injections to dogs of from five milligrammes to one centigramme to animals of from four to five kilogrammes in weight, and found that complete anæsthesia of the posterior limbs down to the very footpads followed. M. Brocard, who adopted the extra-dural method, found that in sixteen cases a half per cent. solution produced relief from pain in sixteen cases of sciatica, one of herpes zoster, one of lumbago, and one of "lightning pains" in the limbs. No unpleasant effects followed, with the exception of

one case, a neurasthenic patient, who complained of headache after the anæsthetic effects had passed away. The pain in every case was relieved within two or three minutes after the injection, and in the cases of sciatica the freedom from pain continued for four days, in some cases, and for two days, at least, in all. The members appear to be agreed that the tolerance of the epidural cavity of the spinal canal is underestimated. M. Brocard injected with impunity 1,000 grammes of serum into the epidural cavity of a dog seven kilogrammes in weight without producing any symptoms of compression. But a profuse polyuria, lasting for some hours, followed. By injecting a dark-coloured liquid into the space, he demonstrated clearly at the autopsy of the animal the rapidity with which absorption takes place in the part. Any modification of the interspinal operation of cocainisation that diminishes its risk will be welcomed by every branch of the medical profession. Cocainisation of the cord, if robbed of its risks, offers to displace all the other methods of anæsthesia in minor surgery. M. Laborde's proposal for extra-dural injection seems a step in the right direction, but it will require considerable skill and practice to acquire the necessary dexterity of manipulation to avoid piercing the membrane and yet inject the canal.

### The Assumption of False Designations.

WITHIN the past few days two persons arrested by the police described themselves as members of the medical profession, and a third, who was found to have beaten a poor woman savagely over the head with a stick, without provocation, declared he was a medical student. He may possibly have commenced qualifying studies and his name be enrolled on the *Students' Register*. For the honour of medicine we hope it is not, but if it should be we hope it will be struck off. The leaven of such men must be kept out of the profession if it is to retain the honoured place in public esteem it has so long enjoyed. But are the men who so often figure in police reports as doctors and medical students really what they pretend to be? In nine cases out of ten we have failed to verify the names on searching the official *Register*. The statement is apparently made to excite sympathy from a public that naturally esteems medical men as their best friends in sickness. The impostor trades on this. He shelters himself under the cloak of medicine, and would pass off his blackguardism and brutality as the innocent jocularity or frivolity of the medical student. The constable takes the description and carefully enters it in the station-book and the charge-sheet. The lie is again repeated before the police magistrate, and thus finds its way into the daily papers until many respectable members of society come to think that a large number of medical men and students are to be found as *habitués* of the police cells. This dirt-throwing on the medical profession should be

stopped. Our ranks are not recruited from "corner-boys," and no profession calls for greater sobriety of conduct from its members. It is intolerable that every ruffian found in a drunken row should bring discredit on the profession by a lie easy of detection—a lie told deliberately to excite a friendly feeling in the audience and take off somewhat from his richly-deserved punishment. In every police-court there should be a copy of the *Medical Register* and of the *Medical Students' Register*, and any person claiming to belong to the profession should be compelled to prove it; and this not in palliation, but rather as an aggravation of his crime. If it should so happen that a medical man or student be found to have committed a brutal offence, his name should be reported to the General Medical Council. It is imperative that medicine be kept free from all uncleanness; the man coming within her portals must have clean hands.

#### The Hospital "Scandal" at Stockport.

THE Town Council of Stockport appears to be unable to dispose of the charges of misconduct in the management of the Isolation Hospital. The matron of that institution has addressed a letter through her solicitors to the Council, pointing out that suggestions have been publicly made that she had starved the patients and staff for the sake of personal gain. Under these circumstances an independent public investigation was asked for, but declined by the Sanitary Committee on the ground that no useful purpose would be served by acceding to the request. The question was raised later in the Town Council and gave rise to an acrimonious and heated debate. It was stated that the stock of linen, utensils and other things was defective, and that one patient had to have vegetables and pudding on the same plate, whilst another had to wait until a plate was finished with by the occupant of the next bed. The Mayor of Stockport and other members of the Council appear to have objected strongly to any discussion of the matter, because of "holding up the town to notoriety" and to bring the place to disrepute. That standpoint certainly is not likely to commend itself to those who entertain a high ideal of the duties and responsibilities of local governing bodies. The Town Council may decline a public inquiry when demanded by a late official, but they surely can hardly hope to escape the much more public and searching ordeal of an inquiry by the Local Government Board. If the state of affairs at the Isolation Hospital has been anything like as bad as presented by rumour it is a wonder how the matter could have escaped the notice of the Board inspectors.

#### Plastic Operations on the Ureter.

FROM time to time there have been put forward fascinating proposals for the treatment of those cases where loss of substance has occurred in the ureter to such an extent that vesical grafting is not possible. Under these circumstances many methods have been advocated, but in the majority of them experience of

the results has been gained by experiments on animals. Nussbaum, in 1887, suggested joining the divided ends of the ureter by a connective tissue tube, but it must be urged against this suggestion that contraction would almost certainly follow. Rydygier, in 1892, improved on this idea and favoured the plan of constructing the splicing of the ureter from the skin of the abdominal wall. Van Hook has published an ingenious plan for replacing a lost portion of the ureter by means of a diverticulum when it is not possible to implant the duct directly into the bladder. A few years ago a very interesting report was published on the substitution of the upper portion of the ureter in a calf by a decalcified turkey's wing bone, the backflow due to intra-vesical pressure caused the failure of the investigation, but a perfect tube of connective tissue was reported to have formed round the bone. Dr. J. B. Bacon, of Chicago, recommended the substitution of the ureter, where it was wanting, by an isolated piece of bowel, and D'Urso and Favii, of Rome, suggested the Fallopian tube as a substitute in woman. Mr. Henry Morris has now given it as his opinion that it is more than improbable that these suggestions will be accepted by the surgeons of to-day, and he also considers that the condition of the patient under the circumstances in which plastic operation on the ureter is likely to be called for would not be such as to justify a trial of these procedures. Though the surgery of the ureter is young in years it has lately come prominently into notice, for since 1894 about 100 papers on the subject have appeared, whilst from 1890 to 1894 scarcely a dozen articles were published.

#### Police Station Medical Certificates.

SOME points of general interest to the profession have lately arisen at Newcastle in connection with the medical examination of persons charged with being drunk and incapable. Two cabmen in that undesirable position asked to see their own medical men, but in each case the police called in Dr. Baumgartner, who is presumably their official surgeon. The magistrate, Sir Charles Hamond, appears to have adopted the view that a request of the kind mentioned should have been granted. The police, he remarked, should always be very careful in agreeing to the demand of any person who wanted a doctor under such circumstances, because there were peculiarities in the life of every man, and he might readily believe he would be better examined by his own medical man than by a stranger. There is much sound reason in that view of the case, but the police are hardly likely to abandon their somewhat autocratic attitude in dealing with persons taken into custody upon a charge of drunkenness. There is much to be said in favour of a routine medical examination of every prisoner lodged in a police station on suspicion of intoxication. Another of the magistrate's suggestions may be accepted with little hesitation. He has firmly stated

that the opinion of the medical man called to the police station should be reduced to writing, in place of the verbal report at present often tendered to the police. The door to possible abuse thrown open by the slipshod method of statement by word of mouth is so obvious that it is a wonder any responsible magistracy could accept evidence of the kind.

#### Pathology at the London Hospital.

THE Hon. Sydney Holland struck a true note when he said that the new Pathological Institute at the London Hospital was a recognition of the responsibility which rests on the management of the largest hospital in England with its vast power of doing good and lessening misery and suffering, and with its equal power of doing mischief if it refuse to advance. Mr. Holland and his House Committee have realised that it was their duty to provide accommodation for men whose life is spent in the specialised work of investigating the exact cause of death by the scientific methods which the great advances in bacteriology, chemistry, and microscopy have placed at the disposal of modern observers. The number of post-mortems at the London Hospital is from 900 to 1,000 in a year, and in the new Pathological Institute such studies of the causes of disease can now be made under conditions which will secure success and make advance possible and probable. The inauguration of this work was well graced by the presence of Sir Henry Roscoe, Lord Lister, and other eminent men.

#### What Did Mr. Chamberlain Really Mean?

IN the course of a recent great public speech, Mr. Chamberlain made use of a simile not quite in tune with his usual brilliancy. Speaking of the internal dissensions of the Liberal party, he likened them to organisms of a low type called by naturalists fissiparous organisms, which fall to pieces at the slightest touch. Any schoolboy who has studied natural history for a term or two knows that fissiparous division is a peculiar method of reproduction and is independent of outside physical violence. If the Liberals are in an active state of fissiparous division they are on the high road to become a huge numerical army, for that particular method of reproduction proceeds at a phenomenal rate. Mr. Chamberlain certainly did not convey that impression. The risk of similes is proverbial, especially when taken from fields with the topography of which the author is not altogether familiar.

#### Suggested Alteration of Title, Royal Medical Benevolent College.

LORD ROSEBERY, the President of the Epsom College, objects very much to the full name and title of this institution. His idea is that to call Epsom College the Royal Medical Benevolent College is to use a superabundance of adjectives. Even the boys at Epsom College, according to Lord Rosebery, dislike the full name with its many epithets, and certainly the suggestion that the insti-

tution should be called Epsom College, with the words Royal Medical Foundation in brackets below, is worthy of all consideration. The Treasurer, Dr. C. Holman, who undoubtedly has considerable influence in the matter, will not consent to shortening the name because it may affect the amount of subscriptions. This, of course, is a perfectly reasonable opinion, and few men are in a better position to judge of the correctness of the conclusion than Dr. Holman.

#### Cough.

A SIMPLE faith in the efficacy of cough mixtures is apt to be rudely shaken by the study of the numerous reflexes through which the exciting impulse may travel, independently of pulmonary and bronchial irritation. We are told that there are fourteen recognisable varieties of useless cough, that is to say, cough which has not for object to rid the respiratory apparatus of irritating secretions. It is a matter of clinical experience that quite a number of coughs are caused by some abnormality in the nose, ear, and throat, while others are, with equal plausibility, ascribed to disordered states of the stomach or some other distant organ. This fact adds singularly to the difficulties with which the physician has to contend in his endeavour to ascertain the source of, and to relieve, the cough. One of the most fruitful sources of reflex cough is the presence in the nose or pharynx of varicose veins or some form of local hypertrophy, consequently the examination should commence in these regions. The root of the tongue is a common site of varicosities, but the epiglottis is often involved, and if success is to attend our efforts to relieve local treatment is indispensable. Apart from obvious structural changes, the existence of hyperæsthetic areas on the nasal mucous membrane and on that of the vault of the pharynx may and do determine a dry, irritating cough, exceedingly difficult to subdue, except by the discovery and treatment of such areas. The probability of a cough being of reflex origin may be inferred when it is spasmodic, practically constant, and accompanied by little or no expectoration, especially when signs of pulmonary disease are absent and when the symptoms persistently resist all medication for permanent relief. The presumption is strengthened if the general health is not thereby obviously affected, and the diagnosis will be absolutely confirmed when, upon removal of the assumed cause, it promptly disappears.

#### An Overlooked Factor in Ear Disease.

THE remedial treatment of ear disease culminating in deafness is, on the whole, so unsatisfactory that every suggestion as to causation is worthy of passing consideration. That the field of investigation is as yet far from closed is evident from the comparative inefficacy of the means employed for the relief of such conditions. In a recent number of the *Journal of the American Medical Association* Dr. Jackson calls attention to the influence of hypertrophic thickenings on both sides of the vomer near

the posterior free margin. The effect of these hypertrophies is to deflect the incoming blast of dust-laden, cold, dry air, and to cause it to impinge on the Eustachian eminences, thus setting up a chronic state of irritation of the mucous membrane in the vicinity of the tube mouths. This action, he points out, is independent of any harm such hypertrophies may do in increasing pre-existing stenosis. These growths are usually soft, though but slightly erectile, and, like the anterior spurs, which however are soft only at first, they are produced by the vascular stasis resulting from pressure against the membrane covering the vomer by the hypertrophied or swollen turbinals, usually the inferior. Normally the inspired air deposits suspended particles in three places before it reaches the larynx. First, on entering the nose the current passes upwards and strikes against the anterior inferior portion of the septum and the anterior end of the middle turbinal. Thence the current is deflected and strikes the posterior pharyngeal wall. In the normal nose the Eustachian eminence is well out of the way of the blast of air, but the presence of abnormal thickenings of the kind described directs it on to the Eustachian areas, and in this way may ultimately determine the form of deafness dependent upon obstruction of this channel of aerial communication with the middle ear.

#### Fads in Medicine.

A FAD in medicine may be defined to be a trivial fancy adopted and pursued for a time with irrational zeal, or a matter, whether important or unimportant, imperfectly understood and taken up and urged with more zeal than sense. Fads of this kind are certainly more common in medical matters than in any other department. Although the tenacity and frequency of such fads are usually in direct proportion to the ignorance of the faddist, we are fain to admit that a tendency to fads is occasionally met with even among the followers of *Æsculapius* themselves. Every new remedy, introduced with a flare of trumpets into therapeutics, becomes for a time the subject of the faddist, but this, perhaps, is more or less inevitable, because those who have hitherto failed to obtain the relief for which they crave from existing remedies are certain to give a trial to every new claimant to their confidence. The worst form of fad, however, is that which leads its victim voluntarily to restrict his diet, either in quantity or by the elimination of many useful articles of food. Another is that in which the faddist pins his faith to some nostrum of unknown composition, and administers it to all and sundry with touching indifference to their special symptoms. It is especially on the borderland of medicine that the fad flourishes most freely. Osteopathy, Christian Science, are modern examples of the "fad gone mad," but hypnotism and electricity for long years defrayed the craving of the ignorant for a universal panacea. Human nature forbids the hope that the fad will ever be exterminated, but it is all-important that medical men should jealously guard their independ-

ence of mind and steer clear of unjustifiable faith in any particular measure or group of measures for the cure of disease. To yield to such a tendency is to degrade the practice of medicine and to abandon all the advantages associated with the progress of science.

#### "Higher" Dental Degrees.

IF there be any one thing that has done more than another to bar the unity and the progress of the medical profession as a whole, that accursed thing is the multi-portal system of entrance into the inner precincts of qualification. That fact stands out as a kind of rock which the medical reformer selects as the base of his operations. For generations past those who have been crying in the wilderness for changes that are still to come have inscribed upon their banner the watchword of a one-portal system. It certainly savours of the backward path, therefore, when the dentists begin to create distinctions and variations of examination standard in their special qualifications. Something of the kind, however, appears to be in the mind of those responsible for the regulations of the University of Birmingham. They do not propose to grant any qualifying licence to practice dental surgery, a position that is understandable enough. What they have done is to invent a new degree in the shape of a Bachelorship of Dental Surgery, which is open to those who have obtained a registrable license elsewhere at least a year previously. The curriculum involves several extra subjects and extra courses, and the examination in the case of anatomy and physiology will be identical with those passed by ordinary medical students. Why a young and enterprising University should revert to the exploded multi portal system at this time of day is an inexplicable mystery.

#### Instrumental Imperfections.

IN no department of surgery, perhaps, is it more necessary for the operator to pass his instruments in review before using them than in laryngological and nasal work. Several instances are on record in which the nozzles of insufflators or sprays have become detached and have actually fallen into the larynx or even beyond, with, in some instances, very untoward and even fatal results. One such incident occurred in the practised hands of the late Sir Morell Mackenzie, and although his distinguished patient ultimately coughed up the foreign body it was not until after a period of intense anxiety to all concerned. More recently two cases have been reported in which the curette used for the removal of adenoids broke off at the junction of the sharpened spoon with the shaft. In one case the piece was removed without incident. In the other it was swallowed, and the piece was passed in the stools three days later. Similar accidents have occurred in the hands of dentists, and have given rise to actions for damages, happily unsuccessful, because it is hardly fair to hold the dentist responsible for defects which he could hardly be expected to be cog-



nisant. The moral is that care should be taken as a matter of routine to inspect an instrument before using it. The consequences of the entrance of a foreign body into the trachea are such as to make the boldest shudder, in view of the extreme difficulty of removing the intruder.

#### The Results of Four Years' Inoculation against the Plague.

IN a recent number of the *Indian Medical Gazette* Major Bannerman, I.M.S., gives the results of four years' experience of preventive inoculation in restricting the spread of plague. Up to the end of last year no less than 1,628,696 doses of anti-plague vaccine had been issued from the Plague Research Laboratory at Bombay, and in all cases in which accurate returns were obtainable, Major Bannerman is enabled to state that "without exception there has been a striking reduction in plague mortality, and a markedly favourable effect on the case incidence has been produced." The returns which he gives from the various plague centres appear to justify this encouraging statement, and they are well worthy of attention by those who are interested in forming a trustworthy opinion on the value of Professor Haffkine's method. We agree with our contemporary in the view that no one who studies this report can do other than believe in the efficacy of inoculation as a protective measure against plague. Major Bannermann concludes his report with the assurance, based on experience, that, to begin with, inoculation is harmless, that when given in the incubation stage it appears in most cases to abort the disease; further, that inoculation confers a high degree of immunity against an attack, and thus reduces the number of cases, and that when an inoculated person is attacked his chances of recovery are greatly enhanced.

#### Can Anæsthesia be Induced During Sleep?

IN the course of a recent trial it was stated by an expert medical witness that it was not possible to produce anæsthesia in the case of a sleeping individual, and it does not appear that this statement was challenged in cross-examination. It might easily have been pointed out to the Court that no less an authority than Dolbeau found that only three persons awakened out of a series of nine to whom he administered chloroform while sleeping. Dr. Leonard Guthrie is said to have frequently attempted to have chloroformed children in their sleep, but without success; but on the other hand, Dr. Dudley Buxton has no doubt that chloroform may in some cases be so administered, though he is less sure about ether. These views have an important medico-legal bearing, because anæsthetics are sometimes administered with a criminal purpose. It is difficult to understand how ether can be used for successfully placing a sleeping person under anæsthesia, but it is asserted by Dr. Turnbull that either chloroform or ether may be administered during sleep without awakening the subject of the experiment. Dr. P. G. Paugh has reported three cases,

all boys between the ages of four and nine, in which he succeeded in accomplishing such anæsthesia. Chloroform was used in each case, and no great difficulty seems to have been encountered, the probability being that the patients in these cases were exceptionally heavy sleepers, in which case it is quite conceivable that an expert anæsthetist would not experience any insurmountable difficulty.

#### Camphor in the Treatment of Varicose Ulcers.

CAMPHOR is a drug which for many years was held in great esteem, especially in extra-professional circles, indeed the late M. Raspail founded a school of therapeutics which still rejoices in great popularity in France, based on the use of camphor internally and externally as a curative agent. Its anti-spasmodic properties, though well authenticated, have of late fallen into disrepute, or at any rate into disuse, and externally it is only employed in this country in the form of a liniment of which it is but a subsidiary constituent. Two German physicians have recently called attention to the value of camphor dressings in promoting the cicatrization of varicose ulcers of the legs which are notoriously refractory to treatment. They make use of an ointment containing 2 per cent. of camphor with from fifteen to twenty parts of oxide of zinc, or, if this be found too irritating, they prescribe a mixture of two parts of camphor with forty parts of zinc oxide, and fifty parts of olive oil. An alternative application is a solution of the drug in spirit, but this must only be applied after the ulcerated surface has been thoroughly cleaned of scabs and crusts by poultices. It is asserted that under this treatment the most obstinate ulcer will cicatrize within three weeks, which is more than is claimed for the much lauded oxygen treatment, over which, moreover, it has the advantage of being more generally applicable at a vastly smaller cost.

#### The Toxic Effects of Cantharides.

IT might be said that it was unnecessary to draw attention to the toxic properties of cantharides when externally applied; but we think that the younger members of the profession hardly realise the fact that not alone in the extremes of life, but that in young vigorous adults also this toxic effect is produced. Even in the lower animals the tendency to produce nephritis is well known. We must, however, make an exception in favour of the common hedgehog, M. Khorvat (*Vratch*, 1897) having failed to produce toxic symptoms in the animal by a free use of the drug. The difficulty the prescriber is placed in is that there is no means of knowing what class of patient the drug disagrees with. It is a safe rule never to apply a cantharidine blister to an infant; but all ages are liable to the toxin, and Signor Muratori (*Gas. Osped.*) has just published a case of severe nephritis following on the application to the back of the thigh of a cantharidine blister in an adult eighteen years old and in robust health.

### Calcium Carbide in Inoperable Uterine Cancer.

THE employment of carbide of calcium as an application in cases of inoperable uterine carcinoma dates from 1896, and it seems to have come into favour in the United States, though its use is not unknown in France and Germany. In contact with the secretions the carbide liberates acetylene gas, which is stated to have a distinctly escharotic action on carcinomatous tissue, in addition to its antiseptic action, which inhibits the bacteria of putrefaction, and, *pro tanto*, reduces the fœtidity. It transforms the necrotic area into a clean, contracting, granulating wound, and the tendency to hæmorrhage is greatly diminished. Its use is said to be unattended by any painful or injurious collateral effect, and it greatly adds to the comfort of the patient, whose death may thereby be indefinitely postponed. We are unable to detect in the claims that have been advanced in favour of this treatment any element of therapeutical novelty. Its effects, such as they are, can be obtained by less offensive agents, and the suggestion that it may in some cases produce a complete cure must be dismissed as absurd.

### Probable Origin of the Heat Wave.

REPORTS of the meteorological offices in America have appeared regarding the amount and extent of the atmospheric heat there and its results, but they have not yet, it seems, vouchsafed even a plausible explanation of the origin and maintenance of the phenomena of the heat wave. There may, however, here be hazarded a suggestion to satisfy the curiosity of the general inquirer that this abnormal air heat is probably local and not cosmic, and that there need be no fear of its spreading outside the States. The heat is not reported extending over the sea or the coasts, or in the great lakes, so that it is probably purely terrestrial and dependent on the condition of the soil or country surface. In the populated States the progress of colonisation has brought the deforestation of the valleys and hills, for the purposes of cultivation, tillage, and pasturage, roads, railways, and towns, with log huts, and firewood, and this clearance has extended into the plains and prairies, which also contribute a quorum by their fires. It is probably bringing slowly on a condition of the earth's surface there as appears in an exaggerated form in the deserts of Sahara, Persia, Australia, Mongolia, &c., where no vegetation exists for sheltering the bare earth from the hot sun, or attracting moisture from the clouds. The consequence of this would be aridity of the air over the country, and no moisture to take up the sun's rays by clouds, and this state of matters in the climate tends to repeat itself, and to prolong itself, till some atmospheric storm cyclone sweeps down from the tropic, or blizzard comes from the polar regions to disturb the heat bank formed over the States.

DR. E. K. BROWN has been appointed Medical Officer of Health for the borough of Bermondsey.

### PERSONAL.

MR. HENRY GREENWAY HOWSE, [F.R.C.S.Eng., M.S. and M.B.Lond., Senior Surgeon, Guy's Hospital, has been elected President of the Royal College of Surgeons of England.

MR. THOMAS RICHARD JESSOP, F.R.C.S.Eng., J.P., Consulting Surgeon, Leeds General Infirmary, and Mr. F. Howard Marsh, F.R.C.S.Eng., Surgeon to St. Bartholomew's Hospital, have been elected Vice-Presidents of the Royal College of Surgeons of England for the ensuing collegiate year.

DR. ANDERSON, who for about ten years has been the Blackpool Medical Officer of Health, has been appointed to a similar position at Capetown. The salary is £1,500 a year.

MISS MALCOLM, sister of Sir James Malcolm, Bart., of Balbedie, has bequeathed a legacy of £4,000 to St. Andrews University for the purpose of establishing medical bursaries or scholarships.

DR. A. E. PORTER, Assistant Medical Officer of Health for the county of Essex, has been selected out of nineteen candidates for the post of Assistant Health Officer for Leeds, at a salary of £300 per annum.

WE regret to learn that Dr. Gilles de la Tourette, a distinguished pupil of the late Professor Charcot, has fallen a victim to one of those mental maladies, in the cure of which he displayed such scientific zeal.

WE regret to record the fact that the death of Dr. James A. Myrtle, the popular Mayor of Harrogate, has been quickly followed by the sudden death of the Mayor of Bolton, Dr. J. E. Scowcroft. Both were in the prime of life and were performing their official and professional duties when stricken.

THE important post of Medical Officer of the Port of London, rendered vacant by the promotion of Dr. Collingridge, has been bestowed on Dr. Herbert Williams, who has been in the service of the Corporation since 1892 as Medical Officer at the Port Hospital, Gravesend, and who therefore has an intimate knowledge of the work and requirements of the Port. The salary attached is £650 per annum.

### Correspondence.

[We do not hold ourselves responsible for the opinions of our correspondents.]

#### THE ATTITUDE OF PHARMACISTS TO PATENT MEDICINES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—We were much interested by some editorials and correspondence which appeared recently in your columns regarding the attitude of pharmacists to the sale of secret nostrums. We feel sure that any pharmacists who have had the matter brought under their notice must feel under an obligation to you for ventilating a subject of such importance to them; and we are glad to learn that several of the leading houses in Dublin are seriously considering the adoption of the label suggested by Mr. Bernard, with the object of disassociating in the minds of the purchasers of secret remedies the fact that the sale of them by a pharmacist implies any recommendation by him. Acting upon Mr. Bernard's idea we had a label printed about twelve months ago as

follows:—"The composition of the contents of this package being unknown to us, we in no way guarantee its effects." We have not used this label very extensively, as we feared we might lay ourselves open to a libel action, and we find that the *Chemist and Druggist*, in a leading article in its issue of June 22nd, inclines to this idea. If it could be shown that the suggested label might be used with impunity, then we have no doubt but that it would become adopted by pharmacists generally, who do not at all love the sale of patent medicines, but are forced by the present attitude of the public towards them to bestow upon them an amount of attention entirely out of proportion to the remuneration gained. The pharmacists of Dublin have their thoughts at present centred on the British Pharmaceutical Conference which meets here the end of this month, and so are not able to discuss at the present moment this important subject; but we trust that during the coming winter something practical may be done.

We are, Sir, yours truly,  
J. GRAHAM AND CO.

[Our correspondents' fear that the use of a label such as they have had printed may involve them in a libel action, are, in our opinion, groundless. We are not in a position to give a legal opinion on this matter, but it appears to us:—

1. That the label in question is merely a statement of fact.
2. That it is affixed with the object of protecting the vendor.
3. That no jury taking into consideration 1 and 2 would decide that it was libellous. It is a matter on which the Council of the Pharmaceutical Society might with great advantage obtain a legal opinion.—Ed ]

VIRCHOW'S EIGHTIETH BIRTHDAY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I learn from Professor Waldeyer that Virchow's eightieth birthday will be celebrated in Berlin on Saturday, October 12th, when he will personally receive delegates with congratulatory addresses from various scientific bodies, foreign as well as German.

A preliminary notice of the intended celebration was given by Sir William Turner at the meeting of the General Medical Council last November to the representatives of the universities and medical corporations on that body; and if such of them as desire to be represented on the occasion will kindly send to me as soon as convenient the names of the delegates appointed I will communicate them to Professor Waldeyer, who is the president of the Executive Committee. Further particulars as to arrangements will be furnished later. The insertion of this letter in your columns would oblige.

I am, Sir, yours truly,  
LISTER.

12, Park Crescent, Portland Place, W.,  
July 6th, 1901.

THE SCIENTIFIC EDUCATION OF MEDICAL STUDENTS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It appears to me that in endeavouring to establish a sort of protection in favour of the medical schools, so far as the scientific education of the student is concerned, the General Medical Council has committed a tactical error which may be fraught with grave consequences. Whatever may be the case with the foremost metropolitan medical schools, it is a matter of common knowledge that the equipment, both in apparatus and in the teaching staff, in the smaller schools leaves much to be desired; indeed, I question whether the majority of them could adequately prepare a student in all branches of science for the preliminary scientific examination of the London University, for example.

But, after all, this is not the crux of the question.

There is no obvious reason why any restriction should be placed on students in this matter. All that the Council is concerned to know is that they have attained a proper standard of knowledge in these subjects, and if examinations cannot be trusted to elicit this fact they must be regarded as useless. The Council loudly proclaims its desire to insist upon five years of medical study, but elementary science is not medical study any more than arithmetic or geography. By all means let us have five years of *bona fide* medical study, to date from the time when these preliminary studies have been completed. I say it with reluctance, but I am fain to admit that the Council's attitude in this matter savours of a desire to increase the revenue of the medical schools, which is not exactly the purpose for which the Council was created. The cost of medical education is already exorbitant enough judged by that of other countries where the teaching is not one whit inferior to that in our own country, without artificially inflating the total.

I am, Sir, yours truly,  
POST-GRADUATE.

THE SUNDAY TIMES AND "SIR JOSEPH LISTER."

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The *Sunday Times* is a bitter opponent of vivisection. The opening of the new pathological department at the London Hospital gave it abundant opportunity for caustic comment. Unfortunately, the sub-editor has allowed the name of Lord Lister to appear more than once as "Sir J. Lister"! This seems not a little curious in an up-to-date censor of the morals of the medical profession.

I am, Sir, yours truly,  
SCRUTATOR.

CHLOROFORM DEATH.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—With regard to your remark as to the death of a child at Guy's Hospital, a week or two ago, that there was no evidence as to how the chloroform was administered, I may say that being present at the inquest I can supply the information. The chloroform was given by the "open" method. The operation was for emphysema of the lung, and death resulted from suppression of breathing in a puny child, the subject of chronic tuberculous disease. The case shows how difficult it is to expect exact evidence from newspaper reports.

I am, Sir, yours truly,  
PRACTITIONER.

Literature.

CABOT'S PHYSICAL DIAGNOSIS OF DISEASES OF THE CHEST. (a)

THIS book, we are told in the preface, is intended for students, and a very useful guide it will be. The descriptions are faithful and good, and the abundant illustrations aid much in making that which is described plain and clear. We cannot agree with the statement that "Nothing is less like a barrel than the 'barrel chest.'" As depicted in the figure, page 15, a good type is given of one form of asthmatic thorax, but this is quite unlike the true "barrel chest" of chronic large lunged emphysema, of which an excellent drawing will be found on page 16.

The instructions as to percussion, specially as to light percussion, are to be commended to the notice of all students.

The author is all in favour of binaural stethoscopes, provided they be not jointed, and numerous illustrations are given of ordinary binaurals and also of the recently invented Bowles stethoscope. This

(a) "Physical Diagnosis of Diseases of the Chest." By Richard C. Cabot, M.D., Physician to Out-patients, Massachusetts General Hospital; Assistant in Clinical Medicine, Harvard Medical School. With 142 illustrations. London: Baillière, Tindall, and Cox. 1901.

stethoscope in its ordinary and multiple forms is fully described. Its value in recognising superficial and fine râles we have proved. The old wooden instrument fails to obtain a notice in this very modern work, though Broadbent and other English observers believe that the slight jar communicated to the ear by the rigid instrument helps to distinguish the first from the second cardiac sound. The remarks on the relative intensity of the pulmonic second sound as compared with the aortic, based on the observations of Dr. Sarah A. Creighton, are interesting as showing the effect of age on this sign. In almost every individual over sixty years of age the aortic second sound is louder than the corresponding sound in the pulmonary area.

The diagrams which are shaded where the murmurs are best heard ought to be very helpful to the student.

At the end of the book some well executed radiographs and fluoroscopic pictures will be found. Those of phthisis in various stages at page 301 (after Walsham) show how far this art has hitherto progressed.

The instructions to guide the observer in cases of early phthisis are given with accuracy; so too are those regarding large lunged emphysema. Atrophic, small lunged emphysema, receives but scanty notice.

A useful addition to the next edition of this book would be a chapter on tubercle bacilli, though this is a matter which does not strictly fall under the head of physical diagnosis.

#### SCHAFER'S "TEXT-BOOK OF PHYSIOLOGY." (a)

THIS huge volume concludes the magnificent encyclopaedia of physiological knowledge which does honour alike to its editor and to the various members of the staff of co-workers. The preceding volume having been issued about three years previously, the only feeling of regret which we experienced on examining that now before us was that a portion or portions of its contents had not been doled out to us long ago. It would relieve the growing feeling of scientific hunger which the good things of its predecessor had made us feel, and from which we suffered in direct proportion to the unprecedented value of its contents. It would also have made the first stage of the mental digestion of the present more enjoyable. Magendie's now too frequently ignored stage of "*prehension*" loomed up before us in all the grandeur of its gloomy responsibility when we greedily laid hold of this voluminous octavo, and became for the first time conscious of its *weight*!

The subjects are numerous, and, as the following list will show, have been judiciously distributed. That of the Mechanism of the Circulation of the Blood has been dealt with by Leonard Hill; Contraction of Cardiac Muscles by W. H. Gaskell; Animal Mechanics by J. B. Haycraft; Muscular and Nervous Mechanisms of the Respiratory Organs, of the Digestive Tract, of the Urinary Tract, and of the Generative Apparatus, by E. H. Starling; Mechanical, Thermal, and Electrical Properties of Striped Muscles, by J. Burdon Sanderson; Nerve, and the Physiology of Electrical Organs, by Francis Gotch; The Nerve Cell, by E. A. Schäfer; The Sympathetic and other Related Systems of Nerves, by J. N. Langley; The Cerebral Cortex, by E. A. Schäfer; The Spinal Cord and the Parts of the Brain below the Cerebral Cortex, by C. S. Sherrington; Vision, by W. H. R. Rivers; The Ear and Vocal Sounds, by John Gray McKendrick and Albert A. Gray; The Sense of Taste and Smell, by J. B. Haycraft.

With such a list of subjects of surpassing importance, and such a staff of authorities to supply information, it may well be expected that the volume under notice should form a necessary part of the mental equipment of every living physiologist and practical physician. Even the most accomplished of the former cannot have already been a master of all the scientific facts and theories which are here to be found, and it is the imperative duty of the latter to the public, to endeavour to make himself master of them as rapidly as he can. There is no

longer any excuse as the material has been placed within easy reach, and this monumental work penetrates the onset of a new era in the history of of physiology in English-speaking countries. It need no longer be said, as it often has been in our hearing, that the first necessary step in becoming even a moderately-skilled physiologist is the acquisition of a sound knowledge of the German language. We can now boldly say that we have as good teachers and as sound theorists at home, and point to the text-book now completed under the editorship of Prof. Schäfer as incontrovertible proof of the truth of our assertion. We need not repeat the old formula of wishing this work all the success it deserves. We feel sure that it *must* have it. We look forward for an early issue of a second edition—and this, we hope, divided into a much greater number of parts.

### Obituary.

#### DEPUTY-INSPECTOR-GENERAL RICHARD DOMENICHETTI, M.D.

THE death is announced, at Woodhall Spa, on Friday last, of this gentleman, at the age of 78. He was the eldest son of the late W. L. Domenichetti, 95th Regiment and graduated at Edinburgh in medicine in 1845, serving afterwards in the 8th King's Regiment and 1st Gordon Highlanders (75th Foot). Dr. Domenichetti was present as senior medical officer in the actions preceding the capture of Cawnpore and the relief of Lucknow, and received the thanks of the President of the Council of India for his services before Lucknow in 1857, with the medal and clasp. Dr. Domenichetti, after retiring from the service, received the honorary title of Deputy-Inspector-General, Army Medical Department, subsequently acted for 25 years as medical officer of health at Louth, Lincolnshire. In 1895 he was appointed Honorary Physician to Queen Victoria, and in 1897 received the Queen's Jubilee Medal.

### Medical News.

#### Society for Relief of Widows and Orphans of Medical Men.

A QUARTERLY Court of the directors of the Society was held on July 10th, the President, Mr. Christopher Heath, being in the chair. Seven new members were elected, and the deaths of four members were reported, and the election of a member declared void. Two fresh applications for grants were read from widows and grants at the rate of £50 a-year made. It was resolved that a sum of £1,284 be distributed among the fifty-two widows, fourteen orphans, and six recipients from the Copeland Fund. The expenses of the quarter amounted to £45 13s. 0d.

#### The Electrical Ozon and Light Treatment.

A MAGNIFICENT installation for the application of the combined electrical, ozone, and light treatment, introduced from America, was opened by a musical *soirée* at 14, Hanover Square, W., on Tuesday of last week, when Mr. Purcell Jones, Mr. Maurice Farkos, Mrs. Max Langemann, and last, but not least, Signor Ancona, delighted a select audience. The visitors, among whom were many well-known metropolitan medical men, were then shown the various appliances for the utilisation of actinic rays produced by a large number of incandescent lamps in a suitable *baignoir*, the atmosphere whereof is largely composed of nascent ozone generated by very powerful Tesla coils. High tension currents traverse the body without the production of any disagreeable sensations, and these currents are applied locally by means of specially constructed vacuum electrodes. Apart from a slight hitch due to the melting of the main fuse the demonstration was very successful and excited great interest. It is hoped that medical men will inspect the very complete and costly installation, and we are pleased to note that in order to secure as far as possible the scientific application of the method, patients will only be admitted

(a) "Text-Book of Physiology." Edited by E. A. Schafer, LL.D., F.R.S. Vol. II. Pp. 1,365. Edinburgh and London: Young J. Pentland. 1900.

to treatment on the recommendation of their medical men.

#### Death from Chloroform.

An inquest was held at Nottingham on the 5th inst., on the body of a little girl, *et.* 7, who had succumbed to chloroform administered for the purpose of removing enlarged tonsils. It was pointed out that ether would not have been suitable for so young a patient, and the usual verdict was returned.

#### Annual Temperance Breakfast of the British Medical Association.

We are asked to announce that the usual breakfast given by the National Temperance League in connection with the British Medical Association annual meeting, will be held on Thursday morning, August 1st, at eight o'clock, in the Parish Room, St. James's Square, Cheltenham. The secretary (Mr. Rae, 34, Paternoster Row, London,) will be glad to send cards of invitation to any of our readers desirous of attending.

#### Health of Belfast.

THE report of the Medical Officer of Health for the year 1900 has just been issued. In the course of it Dr. Whittaker states that although the population of the city has increased during the past year, yet the deaths were less numerous than in either of the two preceding years, numbering 7,642 from all causes, whilst the numbers in the years 1898 and 1899 were 7,768 and 7,933 respectively. The number of deaths from zymotic causes were 50 per cent. less than in the four preceding years, although this decrease does not apply to typhoid fever, the deaths from which still keep abnormally high. Of the number of deaths registered during 1900, 2,899 were attributed to chest affections, and 737 to zymotic diseases—making a total of 3,636, or nearly one half of those registered as having died from all causes. Dr. Whittaker complains that there is no city in the three kingdoms of any importance in which the hospital accommodation for those suffering from infectious diseases is so limited as Belfast. Practically there is but one hospital—the Union—available for the purpose. The total accommodation therein is 250 beds. There were treated in it during the past year 1,261 cases. Although the necessity for an infectious diseases hospital for the city has been long acknowledged, yet but little has been done towards the erection of one. Plans, however, have been prepared and adopted by the Public Health Committee, and he hopes that during the year active measures will be taken to see to the completion of the building.

#### Medical Sickness and Accident Society.

THE usual monthly meeting of the Executive Committee of the Medical Sickness, Annuity, and Life Assurance Society, was held at 429, Strand, London W.C., on 28th ult. There were present Dr. de Havilland Hall, in the chair; Dr. J. B. Ball, Dr. Fredk. S. Palmer, Mr. J. Brindley James, Mr. F. S. Edwards, Dr. M. Greenwood, Dr. St. C. B. Shadwell, and Mr. Horatio P. Symonds (Oxford). The accounts presented showed that the business was satisfactorily progressing. For the time of the year, the sickness claim account was moderate, and a larger number of new members than usual indicates that the advantages of the Society are becoming more recognised by the profession. Few claims were being received for accidents, and a very moderate number of influenza cases had been recorded this year; while the list of members receiving permanent provision of the Society was growing very slowly, as the additions to it were about counterbalanced by losses through death. Prospectuses and all particulars on application to Mr. F. Addiscott, Secretary, Medical Sickness and Accident Society, 33, Chancery Lane, London, W.C.

#### Royal Medical Benevolent College, Epsom.

ON July 9th the Earl of Rosebery, K.G., President of the College, presided at the twenty-eighth festival dinner in aid of its funds at the Hotel Cecil. After the loyal toasts had been honoured, Lord Rosebery proposed the toast of the evening, "Success to Epsom College." As President of the College he suggested that he would like to see the title changed and the institution called simply Epsom College, with the words "Royal

Medical Foundation" as a sub-title; he did not see why Epsom College should not rise to the level of Eton. Present statistics showed that there were fifty foundation scholars in Epsom College for whom exhibitions had to be found from some fund or other, and then there was a difference which had to be met from public funds for those who were sons of medical men and those who were not sons of medical men, besides a considerable number of pensioners. That represented a sum of some £8,000 a year. The fixed income of the establishment was not one-third of that, and considerable reinforcements were required from outside. We have elsewhere referred to the salient points of Lord Rosebery's brilliant speech, which he closed with a strong appeal to the very large company present with the assurance that everything they gave would be well and worthily expended, and that they would have done no better deed in their lives than by assisting to maintain that noble institution. Dr. Holman, the treasurer, followed with an eloquent and at the same time a very practical reply. Personally, he did not object to the change of name proposed by Lord Rosebery, and if those present and their friends would only make the position of the pensioners and foundation scholars secure the adjectives might go; but the difficulty which he had each year to meet expenditure convinced him that unless people had a *quid pro quo* they would not give the money, and the omission of the words "Medical Benevolent" might result in a considerable loss of subscriptions. That was painful for him to say, but it was true. If the Council were provided with £50,000 they would wipe the whole thing out as regards benevolence altogether; but he did not feel justified in doing so without that security. Epsom College was mainly built by John Propert and members of the medical profession, and Propert could scarcely do less than call a college "medical" which was built by the funds of medical men. With regard to the benevolent part, he had seen in his long life the enormous amount of misery among his professional brethren, by sickness, death, and other misfortunes necessarily connected with an extensive and at times dangerous calling, to relieve which in a very humble way Propert instituted the two classes of pensioners and foundation scholars. The needs of the school amounted to about £8,000 a year, though the numbers varied considerably. Since he (Dr. Holman) had been treasurer some £17,000 or £18,000 had been apportioned to foundation scholarships and pensionerships. To diminish in any way the amount of relief which had hitherto been afforded would result in incalculable misery. The toast of "The Chairman" was proposed by Dr. J. L. Propert, a son of the founder of Epsom College, in felicitous terms. Subscriptions to the amount of £4,127 were announced during the evening, including 100 guineas from the Chairman and a donation of 1,000 guineas from an anonymous friend who had been moved to generosity by Lord Rosebery's speech. Lord Rosebery having briefly replied, the proceedings terminated. Thanks to the dinner committee, the arrangements were of the most perfect kind, and a most pleasant evening was the result.

#### The Mortality of Foreign Cities.

THE following are the latest official returns, and represent the last weekly death-rate per 1,000 of several of the populations:—Calcutta 144, Bombay 41, Madras 43, Paris 17, Brussels 13, Amsterdam 14, Copenhagen 14, Christiania 10, St. Petersburg 24, Moscow 46, Berlin 17, Hamburg 14, Breslau 23, Munich 21, Vienna 17, Prague 23, Buda-Pesth 16, Trieste 23, Rome 16, Venice 17, Cairo 34, Alexandria 32, New York (including Brooklyn) 17, Philadelphia 15.

#### Royal Colleges of Physicians and Surgeons of Edinburgh and Faculty of Physicians and Surgeons of Glasgow.

A SPECIAL examination for the Diploma in Public Health was held in Edinburgh in June, and the following candidates having passed the First and Second Examinations, received the Diploma in Public Health:—Mrs. Euphemia Stoker, L.E.C.P. and S.E., Sheffield; Major Robert Caldwell, F.R.C.S., Eng., R.A.M.C.; George Melville, M.B., C.M., Penicuil, and James Sinclair Tait, F.R.C.S.E., St. John's, Newfoundland.

## Notices to Correspondents, Short Letters, &c.

☞ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a distinctive signature or initials, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the publisher or printer before the type has been distributed. This should be done when returning corrected proofs.

ORIGINAL ARTICLES OR LETTERS intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

READING CASES.—Cloth board cases, gilt lettered, containing twenty-six strings for holding the numbers of THE MEDICAL PRESS AND CIRCULAR, may now be had at the office of this journal, price 2s. 6d. These cases will be found very useful to keep each weekly number intact, clean, and flat after it has passed through the post.

### PROPOSED EXAMINATION QUESTIONS FOR FOURTH YEAR STUDENTS.

An irrepressible correspondent has inflicted the following upon us:—

What is the most suitable treatment for chimney sweeps' cancer? How would you proceed to disgnose mitral regurgitation in the fetus third month of pregnancy?

When performing the operation of ovariectomy would you pocket the fœe or the pedicle first?

The extirpation of the uterus and the complete occlusion of the vagina has been recommended as the radical cure for "leucorrhœa." Can you suggest a milder form of treatment, and one equally successful?

Is the reduction of hernia always accompanied by a guttural sound? What is the largest dose of iron you would shrink from taking (ironically speaking)?

Stale bread has been highly spoken of as a cure of juvenile consumption. Explain the rationale and give the author's name.

Why is "opening medicine" prohibited in cases of swallowing penknife or scissors?

How would you proceed to treat a case of chronic vomiting in which the patient "threw up" his employment?

A. D.

MR. J. M. M.—We cannot trace the article to which you refer. Our French correspondent drew attention to the "injection of quinine in the treatment of cancer" in one of the March issues.

S. E. R. will find his communication has been utilised editorially in our present number.

### THE ANTI-MICROBIC MANIA.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In these days of sterilised milk, &c., &c., when war is waged against the microbe, I was much interested in observing four begrimed dustmen, fresh from their work, sitting on their baskets by the roadside eating their breakfasts. Their hands were simply black, and yet the gusto with which they enjoyed their thick slices of bread and butter (or more probably "margarine") eaten from their dirty hands direct, would, I fancy, be an eye-opener for the bacteriologist, who would probably (like the barbarians, Acts, chap. xviii., verse 6) look "when they should have swollen or fallen down dead suddenly." "Surely extremes meet, and it would be most instructive to discover the average mortality among dustmen, who must, in London alone, number a small army. Go to the dustman, thou bacteriologist, consider his ways, and be wise.

I am, Sir, yours truly,

ALEXANDER DUKE.

Cheltenham.

RUS IN URBE.—We agree with you that the Finsen light treatment has not yet been placed upon a sufficiently sound scientific basis to warrant the claims made on its behalf. The physicians whose names are connected with the method would do better to discourage newspaper notoriety, at any rate in the tentative stage of the treatment.

W. E. G.—We fear that the drug in question has not fulfilled its earlier claims to confidence. At the best it could only act as a palliative to some of the minor symptoms of the disease in question. As a matter of fact, the condition may be relieved if not cured by the prolonged administration of thyroid gland.

### LONDON SALT EATERS.

THE *Revue Internationale de Therapie Physique* is responsible for the following, which will certainly be news for Londoners:—"Since the English have learnt from the American newspapers that salt is a panacea—a kind of veritable elixir of life—its consumption has considerably increased in all the London restaurants. An English journalist has 'interviewed' the principal restaurant keepers in the City and the West-End, who everywhere declare that the salt-cellar is emptied in the twinkling of an eye. They have now to fill salt-cellar many times a day which formerly still contained salt at the end of a week. Indeed, a restaurant keeper in Leicester Square declared that, on Saturday last, he completely ran out of salt in the evening, and in consequence was put to a great deal of

trouble. *Habitues* of large restaurants continually ask for very salt dishes to be served several times a week, such as 'pickled pork' and 'blusters.' 'C'est une rage, une furie.' In London everything at the present moment is salt. Salt has become the king of comestibles. And still numerous Londoners complain bitterly that during the Exhibition of 1900 the Parisian restaurant keepers salted them too heavily." *Cum grano salis.*

## Appointments.

BAMFORD, T., M.R.C.S. Eng., L.R.C.P. Lond., Medical Officer of Health of the Uttoxeter (Staffordshire) Urban Sanitary District.

BARLOW, T. W. N., M.R.C.S. Eng., L.R.C.P. Lond., D.P.H. Camb., Medical Officer of Health for the Borough of Bootle, and Visiting Medical Officer of the Linacre Hospital.

BROWN, B. C. M.B., B.C. Camb., Medical Officer of Health of Diss (Norfolk) Urban Sanitary District.

COOPER, LUDFORD, L.R.C.P. Lond., M.R.C.S. Eng., Assistant Ophthalmic Surgeon to St. Bartholomew's Hospital, Rochester.

DUNN, F. H., L.R.C.P. Lond., M.R.C.S., Medical Officer of Health of Stevenage (Hertfordshire) Urban Sanitary District.

EDWARDS, R. J. LL., M.B., C.M. Glasg., Medical Officer for No. 1 District and for the Workhouse of Swansea Union.

FAOAN, F. J., F.R.C.S., Lecturer on Elementary Physics at the Catholic University, Medical School, Dublin.

GRIFFIN, W. WATSON, M.B., F.R.C.S. Eng., Ophthalmic Surgeon to the Sussex County Hospital, Brighton.

HUGHES, JAMES BRIDLEY, M.R.C.S. Eng., L.S.A., Consulting Medical Officer of the Macclesfield General Infirmary.

HUGHES, JOHN B., M.B., B.C. Cantab., M.R.C.S., member of the Honorary Medical Staff of the Macclesfield General Infirmary.

MEIKLE, R. H., M.B., C.M. Glasg., Medical Officer of Health of the Darlington Rural District.

PROBYN-WILLIAMS, E. J., M.D. Durh., Lecturer and Instructor in Anesthetics at the London Hospital.

WADE, CHARLES, L.R.C.P. Lond., M.B.C.S. Eng., Medical Officer for the Boacastle District of the Camelford Union.

## Vacancies.

Bishop Auckland.—Medical Officer of Health for the Rural District. Salary £350 per annum. Whole time to be devoted to the office. Applications to the Clerk of the Council, Bishop Auckland.

Oldham Infirmary.—Senior House Surgeon. Salary £100 per annum, with board, washing, and residence; also Junior, £75 per annum, with board, residence, and washing.

Royal Cornwall Infirmary.—House Surgeon, unmarried. Salary £100, increasing by £10 a year, with board (excluding stimulants) and apartments.

University of Sydney, New South Wales.—Professor of Pathology. Salary £900 per annum. Pension £400 per annum after twenty years' service. £100 allowed for passage. Further particulars of the Agent-General for New South Wales, 9, Victoria Street, London, S.W.

## Births.

WHITELOCKE.—On July 8th and 9th (midnight) at Banbury Road, Oxford, the wife of Richard Henry Anglin Whitelocke, M.B., M.Ch., F.R.C.S. Eng., of twin daughters.

## Marriages.

CHARLES—HODGSON.—On July 8th, at the Parish Church, Hands-worth, Staffordshire, John Roger Charles, M.D., to Alice Mary Gertrude, daughter of the Venble. Robert Hodgson, rector of the parish and Archdeacon of Stafford.

CROFTS—HENDERSON.—On July 10th, at St. Peter's Church, Leicester, George Harry Crofts, M.R.C.S., L.R.C.P., son of John E. Crofts, of Leicester, to Margaret Mary, eldest daughter of Duncan Henderson, of Leicester.

HANSON—WALLIS.—On July 10th, at St. Saviour's Church, Eastbourne, Basil Francis Hanson, youngest son of H. J. Hanson, Esq., of Lilecotes, Marlow, Bucks, to Maud Bath, youngest daughter of the late G. A. Wallis, Esq., M.I.C.E., J.P., of Eastbourne.

HUNNARD—POOLE.—On July 9th, at Llanbeblig Church, Carnarvon, by the Rev. J. W. Wyan Jones, Arthur Hunnard, M.B., B.S. Lond., to A. E. Cicely Poole.

KNOX-ROCHE.—On July 9th at the Parish Church, Weston-super-Mare, by the Rev. E. Morris, Robert George Knox, M.R.C.S., L.R.C.P., to Annette, daughter of the late Mr. Francis Roche.

STOKES—GREY.—On July 9th, at the Church of St. Michael and All Angels, Bedford Park, London, John Wilfred Stokes, M.R.C.S., L.R.C.P. Eng., to Doris Louisa, daughter of Mr. and Mrs. Gray.

## Deaths.

BAGOT.—On July 7th, at Leinster Square, Dublin, Edward Bagot, F.R.C.S.I., late of Enniskillen.

DE'ATH.—On July 7th, at Buckingham, George Hanby De'ath, L.R.C.P. Lond., M.R.C.S. Eng., aged 39 years.

HALLIDAY.—On July 8th, at Nottingham Street, Marylebone, Middleton Wood Halliday, L.D.S., R.C.S. Eng., aged 60 years.

MOSES.—On June 3rd, at Amoy, China, of typhoid fever, John Moses, M.R.C.S., L.R.C.P. Eng., aged 31 years.

NICOLA.—On July 8th, at Chautmont-Vexin, France, Thos. Low Nichols, M.D., aged 85 years.

WARNEFORD.—On July 10th, of pneumonia, at Paignton, Devon, Chas. F. Warneford, M.D., late Surgeon H.M. Indian Army aged 79.

# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

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WEDNESDAY, JULY 24, 1901.

No. 4.

## Original Communications.

### THE COMPLICATIONS AND DEGENERATIONS OF FIBROID TUMOURS OF THE UTERUS AS BEARING UPON THE TREATMENT OF THESE GROWTHS. (a)

By CHARLES P. NOBLE, M.D.,

Surgeon-in-Chief, Kensington Hospital for Women, Philadelphia.

THE traditional teaching concerning fibromyomata of the uterus is, that these tumours are of frequent occurrence; that only exceptionally do they produce grave symptoms; that after the menopause they tend to undergo a spontaneous cure; and that only in the rarest instances do they cause death. This teaching, while traditional, has never been universally accepted. It has been combated from time to time by those having to deal with grave conditions arising from the presence of fibroid tumours. As early as 1853 the classical essay of Washington L. Atlee on "The Surgical Treatment of Certain Fibrous Tumours of the Uterus heretofore considered beyond the Resources of Art" appeared. (b) This essay largely consists of a description of the serious conditions resulting from fibroid tumours, together with an earnest plea for their radical removal. Until recently hæmorrhage has been considered the chief, if not the only danger arising from them. It is now appreciated that patients suffering from fibroid tumours are subjected to many other risks that arise from the degenerations and complications of these growths. Necrosis, myxomatous and cystic degeneration of the tumour, calcareous infiltration, associated malignant disease of the body of the uterus or of the cervix, and complicating diseases of the uterine appendages, such as ovarian tumours, pyosalpinx, salpingitis, &c, not to mention the more remote effects upon the alimentary tract, the cardio-vascular, urinary, and nervous systems, may cause death or continued invalidism of such patients, independent of the natural history of the tumour itself.

In estimating the risks of patients suffering from fibroid tumours the profession has been too prone to be guided by the teachings of the past, rather than by the results of the more careful observations of the present. The chief purpose of this paper is to present in detail the nature and complications of fibroid tumours as they are met with in actual practice. It is well known that fibroid tumours of the uterus are frequently complicated by other conditions, but accurate tables of considerable numbers of cases with their complications are conspicuous by their absence. As a contribution to the study of fibroid tumours I wish to report 218 cases, in which various operations have been performed. This report includes all cases of operation for fibroid tumours in my practice. An analysis of this

group of cases, showing the degenerations in the tumours and the various complications encountered, should give a more satisfactory picture of the condition of patients suffering from fibromyomata of the uterus than any merely theoretical consideration of the subject.

It will at once be apparent, from the accompanying analysis that fibroid tumours do not occur in actual practice as an isolated, uncomplicated, morbid condition. On the contrary, patients suffering from these tumours, as we meet them in the consulting-room and hospital, are found very frequently to have in addition serious complicating diseases, not only of the uterus and of its appendages, but also various morbid conditions in the body at large.

In the 218 patients operated upon for fibromyoma uteri to May 24th, 1901, the following complications were encountered:—

Appendicitis ... ..	4
Bilateral hydrosalpinx ... ..	8
Unilateral hydrosalpinx ... ..	5
Hæmato-salpinx ... ..	1
Calcareous infiltration ... ..	5
Cystic degeneration of ovaries ... ..	2
Ovarian cyst with twisted pedicle ... ..	1
Ovarian cyst, bilateral ... ..	2
Ovarian cyst, unilateral ... ..	19
Ovarian cyst, suppurating ... ..	1
Bilateral dermoid cyst; umbilical hernia ... ..	1
Dermoid cyst, suppurating, sinus through abdominal wall ... ..	1
Dermoid cyst with twisted pedicle ... ..	1
Intraligamentous development of fibroid ... ..	10
Retroversion of uterus ... ..	3
Procidentia of uterus ... ..	3
Parovarian cyst ... ..	2
Ectopic pregnancy ... ..	3
Papillary carcinoma of both ovaries ... ..	1
Abscess of ovary ... ..	1
Pyosalpinx, bilateral ... ..	5
Pyosalpinx, unilateral ... ..	3
Salpingitis, bilateral ... ..	2
Salpingitis, unilateral ... ..	5
Myxomatous degeneration of tumour ... ..	5
Cystic degeneration of tumour ... ..	5
Necrosis of tumour ... ..	12
Adeno-carcinoma of body of the uterus ... ..	3
Epithelioma of cervix uteri ... ..	4
Sarcoma ... ..	2
Syncytioma ... ..	1

In estimating the risks encountered by patients suffering from fibroid tumour we shall consider first those growing out of the complications themselves, which we shall classify in three groups. *First*, those which would lead to a fatal result; *second*, those which would threaten the life of the patient; and, *third*, those which would involve more or less invalidism.

1. Of complications which would lead to the death of the patient are the following:—

Ovarian cyst with twisted pedicle... ..	1
Ovarian cyst, bilateral ... ..	2
Ovarian cyst, unilateral ... ..	19

Carried forward ... .. 22

(a) Paper read before the British Gynecological Society, July 11th, 1901.

(b) "Trans." Amer. Med. Assoc., 1853, vol. vi., p. 547.

Brought forward ... ..	22
Ovarian cyst, suppurating ... ..	1
Bilateral dermoid cyst; umbilical hernia ... ..	1
Dermoid cyst suppurating, sinus through abdominal wall ... ..	1
Dermoid cyst with twisted pedicle ... ..	1
Ectopic pregnancy ... ..	3
Papillary carcinoma of both ovaries ... ..	1
Abscess of ovary ... ..	1
Pyosalpinx, bilateral ... ..	5
Pyosalpinx, unilateral ... ..	3
Cystic degeneration of tumour ... ..	5
Necrosis of tumour ... ..	12
Adeno-carcinoma of body of the uterus ... ..	3
Epithelioma of cervix uteri ... ..	4
Sarcoma ... ..	2
Syncoityoma ... ..	1
	68

To these must be added three cases of cancer of the cervix complicating fibroids, in which hysterectomy was not performed, reported in 1897. (a)

Also one case of epithelioma of the cervix complicating a fibroid tumour of the uterus, seen in consultation with Dr. W. Wayne Babcock in 1899, in which the patient's general condition forbade operation. Also a fifth case from my hospital service, reported by Dr. Babcock. (b)

This is Case 2 of Dr. Babcock's report, in which a fibroid tumour of the uterus was complicated by epithelioma of the cervix, making altogether twelve cases of cancer complicating fibroid tumour which have been encountered. Of these fatal degenerations and complications of uterine fibroids, making a total of seventy-one, thirty-two are of the uterus or tumour, and thirty-nine are of the appendages.

2. Of complications threatening the life of the patient are the following:—

Appendicitis ... ..	4
Bilateral hydrosalpinx ... ..	8
Unilateral hydrosalpinx ... ..	5
Hæmatosalpinx ... ..	1
Parovarian cyst ... ..	3
Myxomatous degeneration of the tumour ... ..	2
	23

3. Of conditions leading to more or less permanent invalidism of the patient are the following:—

Calcareous infiltration ... ..	5
Cystic degeneration of ovaries ... ..	2
Intraligamentous development of fibroid ... ..	10
Retroversion of uterus ... ..	3
Procidencia of uterus ... ..	3
Salpingitis, bilateral ... ..	2
Salpingitis, unilateral ... ..	5
	30

It is probably a moderate estimate that seventy-eight of these patients would have died if the complications of the fibroid tumour had they not been operated upon.

It is difficult to estimate the number of deaths which would have resulted from the symptoms produced by the tumours themselves—deaths due to hæmorrhage; to chronic anæmia, leading to degeneration of the heart and kidneys; to pressure of the tumour upon the ureters and bowels; to malnutrition induced by the hæmorrhages and by the increase of intra-abdominal pressure interfering with the functions of the alimentary canal; to the lowered vitality of the patients, increasing their liability to contract intercurrent diseases; to septicæmia from necrosis of the tumours; and to thrombosis and embolism through associated phlebitis. To these must be added the risks of pregnancy and parturition when complicated by fibroid tumour. It can hardly be considered as other than moderate if we estimate that fifteen of these patients would have died eventually as a result of the presence of the tumours, independent of the above complications. This would

make a total of ninety-three deaths in the 218 cases as a result of the tumours themselves or their complications, a mortality of 42 per cent.

In estimating the number of deaths which would occur from the various complications encountered there may be a difference of opinion as to the probable history of the special complications. It should be pointed out, however, that this would merely take away a small number from the list of deaths to add it to the list of invalids.]

It is impossible to know whether my own experience with the complications of fibroids has been an average one, or whether the cases of fibroid tumour coming under my care have been more or less complicated than usual. I am not familiar with similar tables of complications of fibroid tumour based upon a definite number of cases which would afford a basis of comparison. Martin (a) reports the following complications and degenerations:—

Complications of Fibroid Tumours met with in 205 Cases.

Fatty degeneration of tumour ... ..	7
Calcification of tumour ... ..	3
Suppuration of tumour ... ..	10
Edema of tumour ... ..	11
Cystic degeneration of tumour ... ..	1
Teleangiectasis of tumour ... ..	3
Sarcoma of tumour ... ..	6
Carcinoma of cervix uteri ... ..	2
Carcinoma of corpus uteri ... ..	7
	50

It will be noted that he makes no reference to the condition of the appendages, and that thus his table can be compared only in part with my own.

It may be urged with reason that some of the cases included in this table might have been otherwise classified. The cases of cancer and sarcoma of the uterus complicating fibroids and the cases of large ovarian tumours might perfectly well have had a different classification, and in this way the list of complications having a fatal termination would have been decreased. But even allowing for such a difference in classification there can be no doubt that at least a third of the patients would have died as a result of the tumour or their complications.

Some of the more striking complications which have been encountered will next be considered, in order to illustrate more clearly the nature of fibromyomata of the uterus.

One undoubted case of sarcoma of the uterus had the following history: Mrs. G., æt. 51, childless, had been in failing health for more than a year. She had had a fibroid tumour of the uterus for years, which had recently taken on renewed growth.

The tumour was the size of a foetal head. Abdominal section, Feb. 2nd, 1893, revealed a very soft tumour of the uterus, with secondary growths in the left broad ligament. Upon subsequent microscopical examination, the tumour was pronounced a sarcoma. The uterus and its appendages were removed by hysterectomy. The patient died after a few months from the rapid development of the secondary sarcoma in the broad ligament and abdomen. (b)

A case of syncytioma had the following history:—Mrs. K., æt. 31, has had two children and one miscarriage, which occurred between the two labours at term. The

(a) Martin, A., "Pathology and Therapeutics of the Diseases of Women," Boston, 1890, p. 268-272.

(b) I have seen a second case of undoubted sarcoma of the uterus. This was a case of recurrent spindle-celled sarcoma of the cervix. The first tumour was removed at the Women's Hospital of Philadelphia, and the second at the Kensington Hospital for Women. Each time when the patient came under observation the tumour was necrotic, making hysterectomy inadvisable and each time the patient refused radical operation after recovering from removal of the sloughing tumour. This sarcoma was pediculated, and was not associated with a fibroid tumour.

A somewhat doubtful case is that of Mrs. W., operated upon September 19th, 1895. A fibroid tumour undergoing regenerative changes was removed, and a clinical diagnosis of sarcomatous degeneration was made. The pathologist reported that this was probable, but that the tumour was too necrotic for a positive diagnosis. The patient died subsequently of disease of the liver, believed to have been a secondary development of the tumour.

(c) Noble, Charles P., "The Development and Present Status of Hysterectomy for Fibromyomata," "Trans." Amer. Gynec. Soc., 1897, p. 38; *British Gynec. Jour.*, 1897, vol. xiii., p. 48.  
(d) *Amer. Gyn. and Obs. Journ.*, 1898, vol. xiii., p. 402.



youngest child was thirty months old when she consulted me, June 20, 1893. Menstruation was normal until nine months before she came under observation, since which time she has been bleeding almost constantly. She suffered from pronounced anæmia, corresponding with the history of the hæmorrhage. On examination, the uterus was found enlarged by a tumour in the fundus. A diagnosis of fibroid tumour with probable cancer of the endometrium was made. A combined vaginal and abdominal hysterectomy was performed on June 29th, 1893. A fairly normal convalescence followed. She died early in the December following, about five months after the operation. Death was due to secondary involvement of the left lung, and there were numerous small tumours under the skin scattered over the body. When the specimen was examined after operation, a clinical diagnosis of fibroid tumour of the uterus undergoing sarcomatous change was made. The final report of the pathologist is that the case was one of syncytioma. (a)

The two cases following were operated upon during pregnancy:—

1. Mrs. A., æt. 38, nullipara, was pregnant two months. Shortly after becoming pregnant she discovered an abdominal tumour, which on examination proved to be freely movable and pedunculated, very soft to the touch, and was believed to be an ovarian cyst. Abdominal section was performed, December 3rd, 1894. On delivering the tumour it was found to be a soft fibroid with a slender pedicle, which was injured in the delivery of the tumour. This made the removal of the fibroid preferable to its return, in spite of the complication of pregnancy. The pedicle was ligated and divided. The patient made a good recovery from the operation, but unfortunately aborted. Subsequently she gave birth to a living child.

2. Mr. P., æt. 37, mother of four children, suffered markedly from pressure symptoms, due to a large rapidly-growing fibromyoma. Pregnancy was suspected. This was believed to add to the indication for hysterectomy because of the size of the tumour. Hysterectomy was performed June 20th, 1898. Recovery was uninterrupted. Examination of the specimen showed the existence of a twin pregnancy of six weeks.

Of the twelve cases of necrosis of the tumour six occurred in submucous fibroids or fibroid polypi, the necrosis being due to interference with the circulation by the efforts of the uterus to throw off the tumour. In these cases the tumours were removed by operation *per vaginam*. Two died: one from embolism resulting from a septic inflammation antedating operation and persisting after it; the other from advanced endocarditis.

Of the six cases of necrosis of the tumour operated upon by abdominal section all were in bad condition from septic absorption. All would promptly have died from septicæmia without operation. Three succumbed to septicæmia. One died of embolism of the brain. Of the twelve cases of necrosis six died and six recovered, showing the extreme gravity of this condition.

A striking illustration of the fact that the menopause need not bring relief to a patient suffering from a fibroid tumour is the case of Mrs. C., æt. 67, the mother of one child, æt. 40, who consulted me for the relief of intolerable bladder symptoms. She suffered constantly from tenesmus of the bladder, which had resisted long-continued treatment in the hands of others. She had suffered from hæmorrhage of the uterus from the age of thirty-five until the menopause was established at fifty-two. Examination showed a multinodular fibroid tumour, the pelvic portion of which had become calcareous. The subsequent investigation of the case proved that, by pressure on the right ureter, the calcareous portion of the fibroid had caused degeneration of the right kidney. Operation was performed, March 6th, 1900, at the urgent request of the patient, in spite of a bad prognosis, in the hope that the removal of the tumour might afford an opportunity to relieve the bladder symptoms. She died four days later of suppression of urine.

In this connection and as bearing upon the behaviour

of fibroid tumours after the menopause, reference will be made to the case of a physician's wife, seen in consultation some years ago, who had suffered from the age of thirty-five to fifty-three from uterine hæmorrhages before the menopause was established. Subsequently her health improved, but she was never a vigorous woman. When about seventy years of age, after a drive on a rough country road, the tumour became necrotic. An abscess developed, which ruptured into the bowel. A drainage operation was performed, but the patient died septic.

The disappearance of fibroid tumours after the menopause and after labour is a part of the classical teaching concerning the life history of these growths. My own experience adds little in support of this teaching. No instance of a fibroid tumour having disappeared after the menopause has come under my notice. In one case, seen fifteen years ago, a fibroid tumour was said to have greatly lessened in size after labour, as compared with its size before pregnancy. No other similar case has come under my observation since. That one having large opportunities for observation could have had this experience indicates that the disappearance of fibroid tumours as a result of the menopause or as a result of pregnancy is not to be expected. This occurrence is merely one of the curiosities in the history of these growths.

The ages of the patients operated upon, grouped in decennial periods, were as follows:—

Under 20	...	...	...	...	...	1
Between 20 and 30	...	...	...	...	...	6
Between 30 and 40	...	...	...	...	...	77
Between 40 and 50	...	...	...	...	...	76
Between 50 and 60	...	...	...	...	...	20
Between 60 and 70	...	...	...	...	...	7

The remaining thirty-one cases were operated upon *per vaginam*. In these cases the histories are not complete. One of them was between fifty and sixty, and a number between forty and fifty.

From the standpoint of the youth of the patient the following are of decided interest: One, æt. 17; one, 22; one, 24; and one, 26.

The history of the youngest patient is as follows: Miss T., æt. 17, began to menstruate at 13. Menstruation was regular for five months. It then ceased for two years, with the exception of two periods. She then menstruated every two or three weeks, and from July, 1890, until December, 1890, when she consulted me, she had been bleeding constantly. The patient complained of extreme debility from loss of blood. Upon examination a fibroid tumour was found choking the pelvis and, extending half-way to the umbilicus. Operation, March 23rd, 1892.

From the standpoint of the age of the patient it is of great interest that twenty-one patients, including one operated on *per vaginam*, were between 50 and 60 years of age, and seven patients between 60 and 70 years of age. The oldest patient was aged 67. It will be observed that over 12 per cent. of the patients were above 50 years of age when their symptoms caused them to seek relief in operation, at which time, according to the classical teaching concerning the life history of fibroid tumours, most of the patients should have regained their health as the result of the influence of the menopause. The teaching that the menopause ensures the symptomatic cure of the patient does not receive much support from these figures.

It is not feasible to give the exact age at which menstruation ceased in patients operated upon after the forty-fifth year. A large percentage of them menstruated until they were past fifty, and one as late as the fifty-fifth year. No fact in connection with the history of fibroid tumours is more evident than that the menopause is delayed for from three to ten years.

The relation of fibromyomata to sterility is indicated by the fact that of the 218 patients operated upon, only ninety-one had been pregnant. Of the 127 who had not been pregnant, a certain percentage were unmarried. This experience is in accord with the accepted belief that fibromyomata are a cause of sterility.

(a) McFarland, Joseph, "A Case of Deciduoma Malignum," "Proc.," Pathological Soc. of Phila., 1900, vol. iv., p. 86.

In the list of complications no mention was made of the question of adhesions. In numerous cases adhesions were a marked feature—intestinal, appendicular and vesical. This was more especially true when the tumour was complicated by salpingitis in its various forms. Adhesions are often the cause of pain, constipation, and disorders of digestion, and a source of added risk at the operation. Extensive adhesions add definitely to the risks of operation, by increasing the mechanical difficulties encountered.

The relation of fibroid tumours to phlebitis and embolism both before and after operation is well recognised. In 1889, before hysterectomy for fibroids was well established, I saw a well-marked case of phlebitis consequent upon inflammatory changes in a fibroid tumour. In 1900 a very striking case of phlebitis and embolism, with death, came under my observation. Mrs. D., *æt.* 46, multipara, when standing upon a ladder working with the arms extended, was suddenly seized with violent pain in the abdomen, followed by collapse and grave peritonitis. After several weeks the peritonitis improved, but was followed by phlebitis involving the veins on the left side of the neck and left axilla. She apparently made a good recovery from this condition, but some weeks later died of embolism of the brain. The peritonitis was due to torsion of a pedunculated fibroid, resulting in necrosis of the tumour.

Another death from embolism was that of a patient operated upon when septic, as a result of sloughing of a fibroid polypus. She died from embolism twelve days after operation, her temperature never having become normal.

Phlebitis following operations for fibroids is quite common. The exact pathology of phlebitis is imperfectly understood. It is the tendency of surgeons to attribute all accidents following operation to infection, but in many cases of phlebitis following hysterectomy and myomectomy, the *role* of infection is difficult to prove or to believe. The most prominent characteristic of a series of cases of post-operative phlebitis is that the patients almost, if not without exception, are anæmic and prostrated.

The most characteristic symptom of patients suffering from fibromyomata of the uterus is anæmia. It is not feasible to give the exact percentage of patients suffering from marked anæmia in this group of cases, as many of them were operated upon before the present methods for the study of the blood were in use. A large percentage were anæmic, and some of them in the highest degree. The following case illustrates the degree to which anæmia may develop as a result of hæmorrhage:—

Miss E., *æt.* 45, was admitted to the hospital, January 16th, 1901. She was markedly anæmic, the skin having a waxy appearance, and her hands, ears, &c., being characteristically translucent. She had been bleeding almost constantly for months. Examination showed a number of fibroid nodules, and also a small tumour of the right ovary. It was evident that the condition of the patient forbade a radical operation. The uterus was curetted on the 19th, with the hope of controlling the uterine bleeding, so that with proper feeding and treatment her blood state could be improved to the point rendering a radical operation feasible. On the 23rd examination of the blood, gave the following result: Erythrocytes, 2,325,000; hæmaglobin, 10 per cent.; poikilocytosis marked; leucocytosis marked, of the usual type. On February 6th, the following: Erythrocytes, 2,760,000; hæmaglobin, 35 per cent. On March 4th, the following: Erythrocytes, 3,640,000; hæmaglobin, 45 per cent. Miss E. was discharged March 6, 1901, with the advice that she should return for a radical operation so soon as her blood condition had somewhat improved. She was again admitted April 2nd, and on the 4th hysterectomy by supravaginal amputation was performed, removing the fibroid tumours and the ovarian cyst. The blood examination on the 3rd showed: Erythrocytes, 3,770,000; hæmaglobin, 55 per cent. The examinations of January 23rd and April 3rd were made with Gower's hæmaglobinometer, that of March 4th with Fleischel's instrument, and that of the 6th with the instruments of both Gower and Fleischel. The pathologist's notes concerning the examination of January 23rd state that the

estimation of the hæmaglobin was very difficult because of the excessive hæmaglobinemia. The blood was a slightly turbid straw-coloured liquid.

After the curettage Miss E. was extremely ill. Her pulse was very feeble and prostration was extreme. After the hysterectomy she made a good recovery.

It seems hardly credible that a patient could live with such a high grade of anæmia—only 10 per cent. of hæmaglobin. Had the blood-count been made before the curettage was done it is doubtful whether it would have been undertaken, as the danger of administering ether under such conditions is well recognised.

In others of the graver cases of anæmia the result was not so fortunate. The risks of shock, of œdema of the lungs and of septic infection, after operation, are all increased in anæmic patients.

The attitude of those advocating what they call the conservative plan of treatment of fibroid tumours, but which would more properly be called the expectant mode of treatment, with reference to hæmorrhage from fibroids, is difficult to appreciate. They agree that when a patient has become profoundly anæmic from hæmorrhages, operation is indicated, but oppose operation before that state has been reached. It would seem much more logical to operate early, thus preventing the development of a profound degree of anæmia, saving the patient months or years of invalidism, lessening the immediate risks of the operation itself, and very greatly shortening the period of convalescence after operation. When anæmia has become profound and of long duration, at times it is incurable, and usually appropriate treatment must be continued many months to bring about a cure. The secondary effects of chronic anæmia are also difficult to cure, and should therefore, be avoided. This is especially true of the effect upon the nervous system.

The progressive anæmia often engendered by fibromyomata of the uterus has a distinct bearing upon the operative mortality. In certain cases in which a palliative line of treatment has been followed, it may become imperative to operate, despite the transgression of Mikulicz's rule: Never to operate in any case when the hæmaglobin is below 30 per cent.

A certain proportion of deaths also results from thrombi formed in the vessels of the tumour, which, becoming detached, produce emboli and infection in the lungs and other viscera. Besides these alterations in the blood, degenerative changes in the form of fatty degeneration, brown atrophy, hyaline degeneration, and atheroma, have been found in the walls of the heart and blood vessels in numerous cases. Over fifteen years ago, Hofmeier (*a*) collected seven cases of uterine fibromyoma, in one of which sudden death resulted from pulmonary embolism, in two from a high grade fatty degeneration, and in four from brown atrophy of the heart muscle.

In a number of my own fatal cases the immediate cause of death was the rapid onset of pulmonary œdema. Whether in those cases the pulmonary œdema was an extension of an embolic process in the lungs, or from myocardial degeneration, I am unable to say, as it was difficult to secure thorough post-mortem examinations.

Carcinoma and fibroma being such common diseases, it would be expected that they should frequently co-exist in the uterus. In proportion to its relative frequency, the adeno-carcinoma of the uterine body is more often in this association than is the more common squamous epithelioma of the cervix. That the irritative action of a fibroma should predispose to the development of the adeno-carcinoma would seem slightly less plausible than that laceration of the cervix should predispose to that of epithelioma of the cervix. Clinical experience and embryological studies both refute the idea, however, that the benign tumour may undergo carcinomatous transformation. Indeed, even the penetration of the capsule of the fibroid by an adjacent carcinoma is extremely rare. In two of my cases the carcinoma had reached the capsule, but there was no tendency to

(a) Hofmeier, M., Zur Lehre vom Shock (Ueber Erkrankung der Circulations-Organen bei Unterleibsgeschwulsten), *Zeits. f. Gebur. u. Gyn.*, 1885, Band xi., p. 366.

penetrate the substance of the fibromyoma. Von Becklinghausen observed several cases of adeno-myomata in which the glandular tissue present seemed to have acquired malignant properties.

Sarcomatous degeneration of fibroids would seem to be possible, yet the close histological similarity between fibro- and spindle-celled sarcoma and fibromyoma renders it difficult for the pathologist to determine whether a given growth has been malignant from its inception or has been the result of a sarcomatous degeneration in a fibroid. It is generally accepted, however, that the benign tumour may undergo this transformation.

Of the cases of epithelioma of the cervix complicating fibroid tumour of the uterus, one is of special interest, as it occurred in a virgin. Miss H., *et. 54*, was admitted to the hospital, March 26th, 1901. She had been in failing health for a year, the prominent symptoms being increased menstrual flow, dyspeptic symptoms, increasing debility, inability to retain urine, and neurasthenia. On examination there was found an epithelioma of the cervix complicating multiple fibroid tumours of the uterus. The epithelioma was first curetted and burned away. Total hysterectomy was performed on the 28th. An enlarged gland was found over the iliac vessels. This was removed, and under microscopical examination proved to be a secondary squamous cell epithelioma. A good recovery followed, with the disappearance of all symptoms.

According to the classical teaching concerning the history of fibroid tumours, a fatal termination is very rare. At the present time it is not difficult to understand why this is true, because when the condition of patients suffering from fibroid tumours becomes grave, whether from hæmorrhage, repeated attacks of peritonitis, disturbances of the digestive organs, of the vascular system, or the urinary organs, they are submitted to operation. Patients operated upon when in bad condition swell the mortality of operations, and also greatly increase the list of those making poor recoveries after operation. Doubtless in the future the number of cases dying directly as a result of fibroid tumours or their complications will be less than in the past, because in a larger percentage an early operation will be performed. Nevertheless, numerous cases of death from fibroid tumours can be found in the literature. Bishop (a) reports 37 fatal cases which he has collected.

If the cases of fibroid tumour of the uterus which have come under my observation can be taken as representing these growths as a class, it is a fair conclusion that death will result in more than one-third of the cases. In more than one-fourth of the cases the result will be chronic invalidism. This percentage of invalids would be increased by the percentage of cases ultimately ending in death, so that from one-half to two-thirds of the patients having fibroid tumours, which have come under my observation, have been confirmed invalids. Of the remainder, about one-third, but few have not been incommoed to a considerable degree as a result of the presence of the tumours. The percentage of cases in which tumours have been found more or less accidentally is quite small. This estimate of the gravity of fibroid tumours is radically opposed to the classical teaching upon this point.

It is gratifying to contrast the results which can be secured through the resources of modern gynecology with those which follow an expectant plan of treatment. The mortality of hysterectomy and myomectomy is variously estimated at from 2 to 10 per cent. In a series of 345 cases published by myself in 1897 (b), the mortality of hysterectomy by supravaginal amputation in the hands of five American gynecologists was 4.9 per cent.; in a series of 100 total hysterectomies, the mortality was 10 per cent. In a collection by Olshausen (c) of 806 cases of supravaginal amputation the mortality was 5.6 per cent., contrasted with a mortality

of 9.6 per cent in a collection of 520 cases of total extirpation. According to Bishop (*l. c.*) Mr. Christopher Martin reports thirty-five cases of total extirpation, with a mortality of 2.8 per cent.; Doyen, sixty cases, with a mortality of 2.6 per cent.; A. Martin, eighty-one cases, with a mortality of 7.4 per cent. The advocates of vaginal hysterectomy for fibroid tumours report equally as good, if not better results. The results of myomectomy indicate that enucleation is a more dangerous operation than hysterectomy, although, in the hands of trained men, the results are excellent. Kelly (a) reports ninety-seven myomectomies, with four deaths. This is to be contrasted with 307 hysteromyomectomies, with fifteen deaths, or a mortality of 4.8 per cent. reported in 1900. MacMonagle (b) reports sixty-five cases of myomectomy, with no death.

From these reports the estimate that the mortality of hysterectomy and myomectomy varies from 2 to 10 per cent., depending upon the gravity of the cases, upon the operator, and upon the environment in which the operations are done, is quite justified.

We are now able to contrast the mortality of fibroid tumours, including that of their degenerations and complications, with the mortality of operation—upwards of 33.3 per cent, with less than 10 per cent.; also the morbidity incident to the history of fibroid tumours as compared with that which follows operation, in which the comparison is very much in favour of operation. From all the facts presented, the conclusion is inevitable that the proper treatment of fibroid tumours of the uterus is their early removal. Early operation not only greatly lessens the mortality, but what is of more importance, it saves the long period of invalidism, which is otherwise unavoidable.

Believing that the best treatment of fibroid tumours in general is their early removal, the question remains whether there are no exceptions to this rule. The best answer to this is that each case must be decided upon its merits. It is my individual experience that small multinodular subperitoneal fibroids in women of forty years of age or more are the least apt to grow and to cause serious symptoms. Conversely, submucous and intramural fibroids in younger women are the most apt to develop and to cause serious trouble. It has been my experience to meet with but few fibroids which were not producing symptoms, and it is, therefore, my belief that the percentage of cases is small in which operation is not more advisable than expectancy.

## Paris Clinical Lectures.

### MEDICAL TREATMENT

OF

## CANCER OF THE STOMACH.

BY CHARLES ROBIN, M.D.,

Professor of Clinical Medicine, University of Paris.

[REPORTED BY OUR PARIS CORRESPONDENT.]

It appears strange to make this question the subject of a lecture when it is known that gastric carcinoma is an incurable lesion. But I want to show you how you can and ought to improve the condition of these unfortunate patients. When I was a student I was painfully struck by the lamentable state of *abandon* in which these cancerous patients were left. I have seen the best professors manifest complete indifference towards them. Milk diet, injections of morphine when pain was intolerable, iron where there was hæmatemesis, and that was the end of the therapeutic treatment. It was naturally insufficient; by reason of the apathy of the physician, surgeons claimed the treatment of cancer, so much so that at present 75 per cent. of the patients who enter the hospital submit to a curative or palliative operation—pylorectomy and gastrectomy on

(a) Bishop, E. S., "Uterine Fibromyomata," 1901, pp. 27-31.  
 (b) Noble, Charles P., "The Development and the Present Status of Hysterectomy for Fibromyomata," *Trans. Amer. Gyn. Soc.* 1897, vol. xxii., p. 59.  
 (c) Olshausen, R., "Comparison of Results in Supravaginal Amputation and in Total Extirpation of the Uterus," *Zeit. f. Hand. d. Gyn.*, 1897, p. 713.

(a) Kelly, H. A., "Abdominal Myomectomy," *Trans. Amer. Gyn. Soc.*, 1898, vol. xxiii., p. 223; and *ibid.*, 1900, vol. xxv., p. 213.  
 (b) MacMonagle, Beverly, Private Communication, December 29th, 1898.

one hand, gastro-enterostomy on the other. I think it necessary, consequently, to react and to warn you against this tendency, which appears to me to be excessive. For this reason I wish to speak to you to-day on the medical treatment of cancer; we will study later on under what conditions an operation would be justified.

The treatment of gastric cancer aims at a double end: attenuate the sufferings of the patient, nourish them and prolong their existence as long as possible.

The hope of an ultimate cure must be encouraged, and the treatment should be to that end, as there exist other curable affections of the stomach that might be confounded with cancer.

Some years ago I observed in this sense a typical case: a man who presented the classical signs of epithelioma of the stomach—dark vomiting, tumour, emaciation, cachectic condition, &c. In conformity to the rule which I have just indicated, I reserved my diagnosis, and treated the case on its merits; two months later the patient left the hospital cured. It was a false cancer. It is evident that the milk diet alone would have given the worst result. The medical treatment of cancer is consequently more complicated than would first appear. We are going to see what it is.

First of all, you must not fall into the error that we have at our disposition a specific medication for cancer, and yet some distinguished *confreres* have thought at one time to have discovered a curative therapeutic agent. It is thus that Cabazès thirty years ago proposed the employment of *condurango* for the cure of cancer. Rives related that out of fifty-one patients that agent gave him four cures. These results required confirmation. But *condurango* is none the less a useful remedy as a stimulant to the appetite and the digestive functions. It is given under the form of decoction, extract or tincture. The decoction is made with two drachms and a half of the bark in eight ounces of water boiled down to five ounces and fifteen drops of hydrochloric acid added after the secretion is filtered. The patient takes three or four table-spoonful daily. The extract is given at the dose of two to ten grains daily, and the dose of the tincture is from ten to fifty drops daily.

A second therapeutic agent enjoys great favour since the interesting communication made by my friend and colleague, M. Brissaud; I allude to chlorate of soda.

For a long time chlorate of potash was employed in epitheliomata of the tongue and the skin. M. Brissaud did not adopt this agent because it is a poison of the blood transforming the oxy-hæmoglobine into methemoglobine. The author in his communication cited five patients absorbing from two to four drachms daily of chlorate of soda, a dose impossible in the case of chlorate of potash. Under the influence of this treatment the patients were much improved, the cachexia disappeared, and in one case in six weeks the mæna and hæmatemesis had ceased.

Our own experience, and that of several authors, brought me to conclude that if chlorate or soda had not a specific action on gastric epithelioma, it at least acts as a tonic, increases the strength of the patients, and stimulates the appetite. I must not forget, however, to mention one counter indication to the employment of chlorate of soda, and that is the presence of albumen in the urine.

A host of other remedies have been proposed as specifics; I will only mention the principal substances.

Bichromate of potash was recommended by Vulpian at the dose of one grain daily; it irritates the stomach; it should not be employed.

Tincture of *thuya occidentalis*, which had its day,

was recommended at the dose of four drops at each meal, and increased gradually to 100 drops daily. It increases the weight of the patient, and might be ordered.

The extract of chelidoine was proposed by Gré-sensko to cure cancer in general, either as a local application on external cancers such as that of the breast, or used internally against the cancerous diathesis. I have not obtained any good results from it, and cannot advise you to try it. I pass rapidly over other substances such as calago, employed by the doctors of Paraguay, sulphate of aniline, pyocetanine, chloride of gold and sodium, bromide of gold associated with arseniate of soda; all these products have a more or less hurtful effect on the gastric membrane. There remains the important questions of serum and beer yeast, but they belong as yet to the experimental period, and nothing positive can be said of them, although it is possible that useful results may be reached.

To sum up, all the drugs proposed as specifics of cancer should be regarded simply as stimulants of the appetite. The curative treatment does not exist practically by medical means. We will see in another lecture what must be thought of surgical interference.

## THE DETECTION OF LOCULATED FLUIDS IN THE ABDOMEN.

By GEO. M. FOY, M.D., F.R.C.S.,

Surgeon to the Whitworth Hospital, Drumcondra.

SIR THOMAS WATSON, in his classic lectures, writes; "The parietes of the fore part of the belly being soft and flexible you might naturally suppose that the physical morbid conditions they cover would submit themselves to an easy diagnosis. But the truth is . . . the diseases of the abdomen are more hard to discriminate than the diseases of the thorax." Bright taught his class to note "the form and appearance presented to the eye, the form still further discovered to touch, the resistance ascertained by pressure, the sounds elicited by percussion, and, in a few instances, the sounds perceptible to the ear, either alone or by aid of the stethoscope."

M. Louis Rostan (*Traité Élémentaire de Diag.*) illustrates the necessity for the exercise of caution in such cases by the following: An old woman, a patient in his hospital, complained of a severe pain in the abdomen, towards the left iliac region. Her face was flushed, her skin hot, her pulse strong and frequent, her tongue dry, and she was very thirsty. The abdominal pain was aggravated by pressure, and by the movements of the patient. Upon these data M. Rostan diagnosed abdominal inflammation, and he prescribed accordingly. One of his pupils, however, lingered behind, and having removed the patient's chemise saw that the trouble proceeded from an attack of shingles. To-day the physician, when the ordinary methods of diagnosis fail him, calls the surgeon to his assistance, and a laparotomy for purposes of diagnosis is a justifiable and recognised proceeding, but such a step cannot be rightly taken until the less serious methods have been tried, and as a valuable addition to these we wish to bring forward the bimanual method of percussion for the detection of cystic or loculated fluids in the abdomen, as recommended by Dr. John Clark, of Philadelphia.

On bimanual examination of a pelvic mass of questionable consistence, the intestines intervening between the anterior abdominal wall and the tumour may dissipate the percussion impulse of the abdominal hand, and although fluid may be present, a wave of sufficient intensity to be felt by the

vaginal touch is not induced. To overcome this difficulty Dr Clark confines the tumour as closely as possible between the two examining hands, while the percussion is made by an assistant. "With light, quick taps, even small collections of fluid may be detected by the quick, responsive, pulsatile wave passing from the abdominal to the pelvic hand."

In tumours other than pelvic the method has been modified. By pressing one hand deeply in over the hypochondrium, while with the other deep counter pressure is made just below the fixed ribs, the author was able to detect an appendical abscess situated beneath the cæcum and the lower lobe of a downward displaced liver.

Such cases and such tactile methods of diagnosis require from the physician the *tactus eruditus* which comes of long practice and careful observation; but which is almost a lost art since scientific instruments have become so generally adopted. To those who possess the gift the bimanual method of percussion cannot fail to be helpful, and it is worthy of a trial from all.

## CARDIAC DRUGS AND THE VASOMOTOR TREATMENT.

By PROF. GOTTLIEB,  
Of Heidelberg.

[SPECIALLY TRANSLATED FOR THE MEDICAL PRESS AND CIRCULAR.]

SEEING that circulatory disturbances have for result to determine an unequal distribution of blood in the organism, the object of cardiac and vasomotor treatment must be to restore the equilibrium thus destroyed.

Paralysis of the blood vessels, due to the insufficient central innervation of the vasomotor centres, causes the blood to flow into the abdominal vessels, while the peripheral vessels and those of the skin and brain are depleted; the pulse is feeble and the heart only receives an inadequate supply of blood during diastole. This variety of circulatory inadequacy occurs in cases of intoxication resulting from the use of narcotics and during attacks of infectious disease. In such cases the exhibition of cardiac drugs would generally be without effect, since it is not the strength of the heart that is lacking, but that the quantity of blood which it receives is insufficient. But the blood withdrawn from the action of the heart and accumulated in the dilated vessels of the abdomen, can be brought back into the general circulation by the use of drugs acting upon the vasomotor system, through which they give rise to contraction of the vessels in the splanchnic area. To obtain this result, strychnine, camphor, and caffeine are prescribed. Much the same result may be obtained by irritating the skin, or by making cold applications.

Cardiac drugs are used for the purpose of restoring the energy of the heart. They increase the volume of systole, and in this manner tend to remedy the defective distribution of the blood in the organism, which is the usual consequence of most complaints of the heart, accompanied by a diminution in the energy of this organ, an accumulation of blood in the venous system and anæmia of the arteries being the inevitable result of incomplete systole and of insufficient ventricular diastolic aspiration.

Digitalis acts chiefly by strengthening the energy of the heart; its vasomotor effect is of secondary importance. From experiments made on the heart of a frog, it was long since observed that the cardiac systole increases, and that the energy of the ventricular contraction is strengthened under the influence of digitalis. Recently we have succeeded in making the same experiment on warm-blooded animals in

whom the heart was protected from the variable resistance of the general circulation. We are, therefore, no longer compelled to base our conclusions on experiments made upon frogs. By isolating the cardio-pulmonary circulation, following the example of François-Franck and of E. Hering and Bock, we are enabled to study the action of digitalis on the heart, independently of its effect on the vessels; we can also make use of a separated heart, in which the functions are maintained by an artificial circulation through the coronary vessels. I have been able to afford direct proof by this latter method that an increase in the volume of the systole takes place, and by the aid of a special arrangement I satisfied myself that after a dose of digitoxin the energy of the ventricle is trebled or quadrupled.

The increase in the volume of the systole is caused more particularly by a more complete contraction of the cardiac muscle; the ventricle emptying itself with greater facility. This action is the more important in connection with an ailing heart since a failing ventricle becomes less and less capable of getting rid of its contents. Moreover, the slight diminution in the frequency of the pulse, due to the stimulation of the pneumogastric, which occurs in addition to the more strictly cardiac effect under the influence of digitalis, has a beneficial influence on the cardiac function. The diastolic aspiration of the blood of the veins into the cardiac cavity is also favourably influenced by this slowing of the pulse. Consequently the efficacy of digitalis becomes very evident, in proportion as this slowing effect is manifested. The maximum effect of this treatment corresponds to complete expansion of the ventricles during diastole, plus a maximum contraction during systole. The heart in this way pumps a greater quantity of the blood which is contained in the over-filled veins, and propels it into the bloodless arteries.

All drugs acting in a manner analogous to digitalis have, in addition to the action on the heart, a vaso-constricting effect, as I was able to demonstrate anew in my recent experiments. But this vasomotor action is accessory, from a therapeutical point of view; the important factor in combatting venous stasis is an improvement in the cardiac function. The vascular contraction may be of some utility in the sense that the blood is thereby driven out of the congested portal system into other parts of the vascular system, for, in the first instance, it is principally on the portal vein that the vascular action of digitalis is produced; but, if this contraction exceeds certain limits, its beneficial effect is transformed into one very inimical to the organism, since, in consequence of the rise of arterial resistance the work of the heart is needlessly increased.

Camphor does not only act on the heart indirectly through the vasomotors, it also directly increases the irritability of the cardiac muscle. Its action on the normal heart is little marked; on the other hand I was able to convince myself in the case of the rabbit, that under certain pathological conditions, when the heart ceases to beat, it is possible by the application of camphor to combat this momentaneous stoppage and to save the rabbit's life.

Caffeine has a direct effect on the heart, but one quite different from that of digitalis nor can it be considered as a substitute for the latter. As a matter of fact it does not increase the functional energy of the healthy heart in cases where the blood tension is normal, but it strengthens the action of the cardiac muscle in the presence of a pathologically high arterial resistance; it may also be useful in cardiac complaints accompanied by a high aortic tension.

Alcohol has not a direct influence over the heart; it acts indirectly on this organ by diminishing the

peripheral resistance, when in consequence of an exaggerated aortic tension, the left ventricle can no longer completely empty itself. In this case it causes the vessels to dilate, and the resistance to diminish, and as a result whereof the heart carries on its work under more favourable conditions, and is enabled to furnish a greater amount of work.

The various cardiac drugs, it will be seen, act on the circulation in quite a different manner to those which act in the vasomotor system. In spite of the difficulties that present themselves in the study of so complicated a mechanism we may hope that by associating clinical observation with experimental pharmacology we may succeed, little by little, in gaining a deeper insight into the nature of the circulatory troubles which present themselves to our notice, and to choose with more discernment the treatments capable of combating these troubles and of restoring the equilibrium.

### Transactions of Societies.

#### BRITISH LARYNGOLOGICAL, RHINOLOGICAL, AND OTOLOGICAL ASSOCIATION.

GENERAL MEETING HELD JULY 12TH, 1901.

Mr. MAYO COLLIER, F.R.C.S., President, in the Chair.

Mr. MAYO COLLIER showed a case of Double Optic Neuritis with Paralysis of both External Recti following Right Tympanic Disease. The interesting point was the cause of the neuritis. Dr. HAWTHORNE suggested cavernous sinus thrombosis; Dr. DUNDAS GRANT the possibility of tubercle. Dr. WOODS also spoke, and the PRESIDENT, in his reply, objected on anatomical grounds to implication of the cavernous sinus.

Mr. MAYO COLLIER also related a case of Deafness due to Chronic Sclerosis of the Middle Ear, which had been greatly improved after relief of nasal obstruction and showed a case of Epithelioma of the Maxillary Antrum nine months after operation, in which there had been, so far, no return.

Dr. BARCLAY BARON showed a case of Complete Aphonia with Close Approximation of the Cords. It had resisted all treatment, and was brought forward for diagnosis and suggestions for treatment. There was general agreement that the case was functional. Chloroform narcosis, hypnotism, and cauterly to the enlarged veins at the base of the tongue being variously proposed.

Mr. LENNOX BROWNE showed a specimen of a Fibromyxomatous Polypus, removed from behind the palate, and found to have proceeded from the maxillary antrum through the opening in the inferior meatus, made during the course of operation performed some months previously for relief of maxillary empyema.

Mr. LENNOX BROWNE exhibited a case of Pretuberculous Condition of the Larynx in a patient who had been treated by him twenty years previously for Traumatic Perichondritis due to the impaction of a chicken-bone in the larynx. The patient had since developed symptoms which pointed to tubercle, but both pulmonary and laryngeal evidences had been—to say the least—inconclusive. The main feature was recurrent aphonia, but with phonetic cough.

Mr. LENNOX BROWNE also showed a patient with Sarcoma of the Pharynx, who had been exhibited twice previously, first in March before removal, secondly in May after removal, and now again, to demonstrate, first that a certain amount of infiltration suggestive of a possible recurrence had entirely subsided, and secondly in regard to the epiglottis which formerly compressed by the growth had now entirely recovered its form and position.

Mr. LENNOX BROWNE showed a patient, æt. 66, with an enormous tonsil and glandular infiltration which had existed for three months, but up to

now, though causing comparatively little difficulty in swallowing, had been the occasion of severe pain. The microscopical examination revealed that the growth was a sarcoma, and it was suggested that, although quite inoperable, the case was one suitable for treatment by Coley's fluid, of which the exhibitor had had more than one favourable experience.

THE PRESIDENT, commenting on the interest of the case, expressed the opinion that the majority of malignant tumours of the tonsil are sarcomata.

Dr. McCOLL showed a patient suffering from Laryngeal Tuberculosis in an advanced stage, which had been treated by insufflations of resorcin and orthoform. Both deglutition and voice had been greatly improved, and the laryngoscope showed several cicatrices of healing. The general treatment had been that of "open air" and the patient had gained a stone in weight. The President, Mr. Lennox Browne, and Dr. Dundas Grant spoke in congratulatory terms on the result.

Dr. LODGE showed a patient with Lupus of the Nose cured by Excision according to the method of Anderson, with an artificial nose of aluminium made by the patient himself, who, a coachbuilder by trade, had achieved a success far exceeding that of one of ordinary manufacture which was exhibited for comparison.

Dr. DUNDAS GRANT showed (1) a case of Post-Diphtherial Paralysis; (2) Ulceration of the Tongue, probably malignant; (3) Thrombosis of the Jugular Vein.

Dr. WOODS (Dublin) opened a special discussion on  
TUMOURS OF THE PHARYNX FROM THEIR CLINICAL ASPECT.

He related several cases in his own practice both in the naso-pharynx and in the lower pharynx and his methods of operating. The chief interest turned on the advisability of operation.

Mr. LENNOX BROWNE spoke in favour of removal at the earliest possible moment after diagnosis and related several cases, and the PRESIDENT discussed the question from the point of view of surgical anatomy, giving several fatal instances which, from the experience of others, might have been successful had they been attacked with courage in their early history.

Dr. DUNDAS GRANT confessed himself at a loss to account for the undoubted hesitancy of even bold surgeons to interfere with these cases, considering the great advances that had been made in radical operations generally.

Dr. LODGE related a case, and showed photographs of a successful operation for removal of a sarcoma of the naso-pharynx and of involved cervical glands.

Dr. VINEACE drew attention to the success of the case of Mr. Lennox Browne, which, when first exhibited, was almost unanimously pronounced by the Fellows present to be inoperable.

### Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, July 20th, 1901.

#### PATHOGENETIC STUDIES ON PHTHISIS, CANCER, AND SOME OTHER DISEASES.

THIS is the title of an interesting work by Professor Riffel Carlsruhe, in which he endeavours to show the origin of various diseases. The onset of various epidemics observed in four places possessing different kinds of geographical position, drinking water, subsoil, &c., has confirmed an idea already in his mind that the prime causes of diseases are to be sought in the individual himself, and in the peculiar character of his organs and tissues, which become changed from one moment to another, and not alone by the chemical and bacteriological examination of external things, nor by experiments on animals or infection of wounds. The author gives tables of family trees of about fifty

different families, and draws from this material his conclusion that tuberculosis is a distinct disease from phthisis, which is a necrotic process of the lungs dependent on congenital disposition or tendency. The prophylaxis of phthisis lies, therefore, in the avoidance of constitutional weakness. As medicinal means of improving the constitution are not always at hand, residence in mountain curative resorts is necessary, and the furtherance of these institutions is one of the most important hygienic objects.

By far the greater part of the cases of cancer observed by the author occurred in families in which phthisis also had occurred. The presence of the tubercle bacillus in broken down cancer masses is for him a proof of their saprophytic nature.

Regarding puerperal fever the author comes to the conclusion that women who belong to phthisical families are susceptible to septic diseases. With any suspicion of phthisis about them pregnant women in lying-in hospitals should be isolated.

He prophesies that the results of bacteriological achievements in regard to phthisis will eventually prove to be as small as that obtained from the Hamburg cholera epidemic in respect of that disease. In spite of a good deal that must now be considered heterodox in Professor Riffel's teaching, the factors of the individual himself, his organs, and his tissues has of late years been somewhat overlooked, and all disease has too generally been put down to "outside things."

At the Society fur Innere Medizin Hr. Litten related a case of

#### EMBOLISM OF THE PULMONARY ARTERY.

A woman of 70 was brought into hospital a few days ago with symptoms of myocarditis, extensive dyspnoea, irregular pulse, and albuminuria. Death took place suddenly through increased dyspnoea. Section showed the following conditions:—In the lungs firm large nodules, of which four or five appeared as prominences on the surface. They were hæmorrhagic in parts, as shown by cutting into them. The arteries leading to the nodules were blocked even up to the finest branches. On the hilus of the lungs was a large fleshy mass that came from the pulmonary artery of the left lung, which was completely blocked by an embolism the thickness of the thumb, so that not a single drop of blood could pass through it. Here was the cause of the sudden death. When the question came up: whence does this embolic material arise, there were two possible sources, either clotting in the veins or thrombi in the heart. In this case the latter were present; the left ventricle, which was exceedingly dilated, was filled with adherent thrombi; the left auricle with hæmorrhagic infarcts and thrombi in the right heart, especially in the auricle. The emboli had at first passed through the arteries of the lungs and set up the infarcts, and later blocking of the arteries themselves took place.

He remembered a case seen when he was assistant in Frerich's Klinik. A man, æt. 29, was taken in with severe dyspnoea, systolic and diastolic murmurs in the region of the pulmonary artery, and soon died. Section showed the following:—The trunk of the pulmonary artery and the two branches given off were filled with numberless echinococcus cysts, which filled up the lumen of vessels up to those of the third order. The systolic and diastolic murmurs were caused by the

emboli, which prevented complete closure of the valves. There was a question how long the man might have lived with this blocking of his arteries. A little blood might possibly have passed, and the section showed evidences of this in small blood clots at the peripheral ends of the embolus. Whence the echinococcus cysts originated was not ascertained.

The *Munch Med. Wochensch.*, 19/1901, contains the relation of a case of

#### GUNSHOT WOUND OF THE BLADDER

by Dr. Bayerl. A little boy, æt. 8, was accidentally shot by his brother by a small pistol. Examination revealed a small roundish opening just above the os pubis, the borders being bruised and blackened. The opening led to a small canal passing to the right, which could be followed a distance of 5 ctm. The bullet could not be found. From the opening trickled a small quantity of watery fluid (urine), slightly mixed with blood. The boy complained of strong desire to micturate. The next day matters had improved so much that clear urine was passed spontaneously from the urethra, but the next day they became worse again. There was great restlessness and excitement, violent pain in the scrotum with swelling, swelling at the fundus of the bladder, vesicular swelling at the root of the penis, and fever. No urine came through the wound. There was, therefore, infiltration of urine. A number of incisions were now made in the scrotum, penis, &c., and a good deal of urine escaped through the wounds. The pain ceased, however, and the swelling and fever subsided. Three days later the bullet was found in the dressings. Recovery with healing of the wounds now speedily followed, without any necessity for further surgical procedures.

The *Deuts. Med. Zeit.*, July 8th, reports a case of supposed

#### SYPHILITIC PARALYSIS AFTER CHLOROFORM NARCOSIS.

A patient, æt. 34, was operated on for hernia. The stage of excitement was so extreme that the man's arms had to be tied together. Afterwards the patient noticed that the left arm was quite powerless, and that the right arm could only be moved with difficulty. Twenty-three days after the operation the reporter of the case diagnosed bilateral paralysis of the brachial plexus. It was ascertained anamnæstically that the man was an alcoholic, and that five weeks before he had contracted a syphilitic infection. On treatment by inunction improvement took place, and in a few weeks complete recovery. The reporter attributes the paralysis to the syphilis, but paralysis under similar conditions is not unknown where syphilis is out of the question.

## Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, July 20th, 1901.

#### LICHEN AND LUPUS.

SIEGFRIED JANOVSKY at the Prague meeting showed two cases of lichen and several of lupus.

(a) *Ruber planus* in the case of a female, æt. 57, scattered over the body and extremities as brown, flat, waxy lesions, with glancing, horny, shield-like appearance. Arsenic was administered with tar and hydrotherapy to relieve the itching. The disease improved slowly, leaving a brown sepia colour.

(b) *Ruber verrucosa* in a youth, æt. 19, localised on the lower extremities. The efflorescence appeared to be due to an excessive proliferation of the papilla. The feeble constitution and imperfect assimilation of food was in favour of Robinson's theory of the cause of the disease, viz., a great enfeebling of the individual and diminished resistance of the body.

Lupus erythematosus in a typical facial form.—Patient a female, married, æt. 35. Various remedies were applied till erysipelas commenced on the healthy side and extended to the affected side. On recovering from the erysipelas the lupus disappeared also.

The next case was that of a male, æt. 49, which was peculiar from the hyperkeratosis developed on the affected side.

Janovsky related a number of similar cases to the first which were cured with Koch's tuberculin contrary to the opinions of French authors. In seems that the toxin from the tuberculous bacilli has some beneficial effect on lupus erythematosus by awakening some centre not reached by external applications.

The best therapeutic for lupus vulgaris was scarification after Brock's method. He cannot speak favourably of Holländer's hot air treatment, and thought Ullmann's apparatus for treating epididymitis with warm air was certainly more curious than clinically useful.

He also showed a patient from whom he had removed a keloid by means of electrolysis, according to Ehrman, with very happy results. On the first occasion he excised it under the impression of extirpating the disease, but, unhappily, it soon recurred.

#### POTENCY OF ACID FREE ALKALOIDS.

Velich, at the same meeting gave the result of his experience with non-acid alkaloids, such as nicotine, coniine, and piperidin, which were more active in raising the blood-pressure than any of the others; this he attributed to their more energetic action on the vasomotor centres, while the other substances act more on the periphery. To demonstrate this fact is no easy task, as the whole central nerve system must first be eliminated, which means destroying the life of the animal.

If 100 or 200 cubic centimetres of a physiological solution of sodium chloride be injected into the vessels on the right side of the heart immediately after removing the medulla the animal can be made to survive two hours after the operation, which was demonstrated long ago by Spina. By the help of Spina's facts Velich found that nicotine, coniine and piperidin raised the blood pressure by their peripheral action.

If any of those poisons are injected several times in rapid succession this elevated pressure is not observed, but if at this point the extract of the suprarenal body be injected the vessels are rapidly contracted, as if only one dose of poison had been injected.

Nicotine seems to act more through the vessels, while coniine and piperidin act more on the peripheral vasomotor ganglia.

The vessels of the brain, lungs, and retina were exceptions to these drugs, as some of them were contracted by the acid free alkaloids, but on the contrary the vessels of the brain were dilated. Velich cannot say he has yet discovered a drug that causes real contraction of the vessels in the lung.

Whether these drugs have another action on the

medulla oblongata and spinal cord, when *in situ* he will not venture to predict as his experiments were confined to the peripheral organs. In tying the carotid artery close to the subclavian we cannot depend upon the half of the medulla being acted on as the arterial anastomosis is too great to make the experiment of any value.

#### FACIAL PRESENTATION.

Ostreil gave an analysis of 11,513 cases delivered at the "Hebammen" Clinic of Prague, of which fifty-nine, or 0.5 per cent., were face presentations. Of these fifty-nine one-third were primiparæ, and two-thirds multiparæ. This position was no more dangerous for the mother than the vertical pole, except that labour was more protracted. Infant mortality is high, being 41.8 per cent. In six cases, or 10 per cent., instruments were used, with two fetal deaths. In one case perforation was performed; twice turned; while nine were improved by Thorn's manual correction.

Ostreil recommends the earliest possible interference to correct the position according to that recommended by Schatz, which may be easily performed if sufficiently early diagnosed and no complications present.

When the head has descended well into the pelvis, and the os fully dilated, chloroform should be given, and Schatz's method tried; failing this, Thorn's method may be undertaken, i.e., pass the hand into the uterus till the occiput is firmly grasped, which is then drawn forward while the face recedes. This operation is assisted by the second hand manipulating the external surface of the abdomen.

The cause of this position is often attributed to the dolichocephalic condition of the foetus, but Ostreil thinks this a result and not a cause. The primary cause he assigns to the great size of the foetus; in all his cases only eleven of them were under 3,000 grammes. This state shows the chin to fall low and catch on the pelvis.

## Continental Climatic Stations

[FROM OUR OWN CORRESPONDENT.]

### MURREN.

"Where Alps arise."

MURREN claims pre-eminence among the health resorts of the Berner-Oberland for beauty of position, and for unique mildness of temperature at so great an elevation. The village occupies a broad sheltered terrace 5,300 ft. above the sea-level, and face to face with the great peaks of the Jungfrau range, commanding a very near view of an incomparable Alpine panorama. On the left, across the deep valley of the White Lutschine river, the prospect is over the verdant Wengen and the stony Scheideck plateaus, with the snowy summits of the Wetterhorns behind; to the right of these is the precipitous pyramid of the Eiger and the broad snowy outline of the Monch. Yet nearer is the dark mass of the Black Monch, on which can frequently be seen chamois grazing, and above which towers the superb Jungfrau, and by its side the dazzling loveliness of the Silberhorn. Yet more to the right come, one after the other, the Gletscherhorn, Ebnefuh, Mittaghorn, Grossehorn, Breithorn, Tschingelgrat, Gespaltenhorn, Buttlaesen, each great enough in its grandeur to make any other spot notable.

The village has a mixed aspect; old-world chalets



intermingle with *fin de siècle* hotels, of which the premier for position and comfort is the Grand Hotel des Alpes. Murren is an all-year-round residence. In July and August its hotels and pensions are gay and crowded, giving an attractive, lively spectacle of Continental summer life. To many its quieter months of May and June are more attractive, for as soon and as rapidly as the snows recede, its meadows, hillsides, and woodlands are richly decked with flowers; white crocus, violet bells, gentians, anemones, auriculus, and primulas abounding all around, and making the numerous walks "things of beauty," for here Nature has placed the grand and the lovely side by side. One of these walks is to the Blumenthal, a hollow surrounded by mountains and remarkable for its wealth of Alpine flora. For the athletic the heights near Murren afford ample exercise, especially in September, when the very clear atmosphere is most favourable for mountain views.

Among the climatic advantages of Murren may be mentioned:—

1st. Its complete protection at all seasons, although at so high an altitude, by the Allmendhubel and hills further back to the north and west, from bleak and violent winds and against sudden changes of temperature.

2nd. Its very desirable southern exposure.

3rd. Its separation by a ravine-like valley, 1,600 feet in depth, from the immense glaciers and snow-covered mountains immediately *vis-a-vis* to the village. This deep valley has a peculiar beneficial effect upon the evening temperature. During the day the radiation from sun's beams on the precipitous wall of rock upon which the village is built warms the air in the valley. When the air on the heights opposite Murren after sunset becomes cool and heavy, this cooler and heavier air sinks gradually into the intervening valley, forcing up on the Murren side the lighter and warmer air which flows as a warm current over the Murren plateau; an agreeable process often noticeable in the village until midnight.

A sojourn at Murren can be recommended in cases of debility, especially for variations in the composition of blood arising from anæmia, defective assimilation, hæmorrhages, suppurations, fevers, excessive mental exertions and perturbations. It has been very successful for cachexia, malaria, and disorders caused by tropical climates; also in convalescence after pleurisy and pneumonia, in chronic asthma, dyspepsia, insomnia, and early stages of consumption when unaccompanied by hectic symptoms.

Murren is accessible from Interlaken and Grindelwald by railroad to Lauterbrunnen; thence by Funicular to Grutschalp; and thence by electric railway through pleasant fields and woods to Murren village. The water-worked Funicular from Lauterbrunnen will be changed the coming autumn into an electric line, giving greater facility of access, and enabling the Murren hotels to have an excellent winter season. Its southern exposure, equable temperature, and peculiar position will speedily make it a popular home when the change of Funicular has been completed.

HIS MAJESTY KING EDWARD VII. has consented to become the Patron of the Royal Medical Benevolent Fund Society of Ireland.

## The Operating Theatres.

### ST. MARY'S HOSPITAL.

CASE OF MIDDLE MENINGEAL HÆMORRHAGE.—Mr. H. STANSFIED COLLIER operated on a man, *æt.* 40, who had been admitted after having fallen from his bicycle on to his head. He had been picked up in an unconscious condition, but when brought to hospital he had regained consciousness. He was bleeding considerably from the right ear, and his left hand grasp was a little weak. He expressed himself as not being much hurt, and Mr. Hunt, the House Surgeon, had some difficulty in persuading him to stay in. Three hours later the patient showed a definite left hemiplegia, and very rapidly became unconscious, and had a very slow pulse. The circumstances being very urgent, three hours and a half after admission he was taken to the theatre, and Mr. Collier turned down a large flap of scalp from the side of the head, and found a linear fracture crossing the base of the mastoid process from behind forward. A disc of bone was removed from the parieto-mastoid junction, and an enormous extra-dural clot was discovered, but no tear of the dura mater. A second disc of bone was now removed at the anterior inferior angle of the parietal bone; it was then ascertained that the dura mater was separated over nearly the whole of the right half of the vault. By the aid of a suitably curved Volkmann's spoon some ounces of firm clot were removed. While this was being done sharp bleeding continued, and this was with difficulty arrested by plugging with strips of cyanide gauze which were passed down through the anterior trephine hole towards the foramen spinosum. At the completion of the operation the cavity from which the clot had been removed was still present, and there seemed to be no expansion of the cranial contents. Mr. Collier remarked that this case was an excellent example of middle meningeal hæmorrhage, and that the sequence of transient unconsciousness, recovery of consciousness, and hemiplegia, followed by a relapse into an unconscious state, was particularly well illustrated; the pouring of venous blood from the ear had made him at first a little uncertain as to the diagnosis, because he had seen a similar group of symptoms resulting from intra-dural hæmorrhage from the lateral sinus; it was on this account that he had made the posterior trephine hole. In this case, he pointed out, it was clear that a fracture of the base ran through the petrous bone into the greater wing of the sphenoid and the middle meningeal artery was ruptured very close to the foramen spinosum. Failure on the part of the cranial contents to expand was probably in part due to the condition of shock, the cardiac failure being very obvious; in addition perhaps the brain was actually buckled in towards the ventricle. To stop the hæmorrhage it might appear to be better, he said, in such a case to tie the external carotid, but the collateral circulation is so free that this procedure might not stop the bleeding altogether, and one would have the disadvantages of operating on a neck which was unprepared by antiseptics. He pointed out that the plug as he had inserted it would not be large enough to cause any serious compression, it would be removed the next morning, and in spite of the shocked condition of the patient he would hope that he would do well.

The man rallied well, and was conscious three or four

hours after the operation. Five grains of calomel were given, and some bromide of potassium to combat the restlessness. Next day the paralysis had disappeared, and the man was discharged cured in a fortnight.

REGISTERED FOR TRANSMISSION ABROAD.

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## The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, JULY 24, 1901.

### THE "LIGHT" AND OTHER TREATMENTS.

RECENTLY a sub-committee of the British Medical Association has passed in solemn conclave a resolution that it is a breach of professional ethics for any medical man to allow his photograph to be published. As an abstract resolution the standard of that decision stands high, but when reduced to practice it will, in all likelihood, sink at once to the futile level of a pious opinion. The truth of the matter seems to be that veiled advertisement finds its fullest and most skilled expression among the higher ranks of the profession. Any candid reader who thinks for a moment of the scores of photographs of professional brethren that have come to his notice in lay journals will be able to form a decided opinion not only as to the extent of the practice, but also as to the status of these victims of editorial pushfulness. But if it be wrong in principle to obtain public newspaper notice in the form of portraiture, it is clearly no less culpable for a physician or surgeon to have his name lauded in the lay journals in connection with this or that treatment. Yet this kind of thing has been going on for a year or more in connection with one of the largest of our London hospitals. We allude to the systematic press notices of the Finsen light treatment of lupus and certain other skin conditions that have appeared in the public press, together with specific and repeated mention of the names of certain medical men. To some extent the gentlemen thus invidiously selected for journalistic attention must command our sympathy in their somewhat painful position. If this sort of thing is to be permitted in high places, however, there is no reason, at any

rate on the surface, why a similar means of getting in touch with the public should not be wilfully and knowingly adopted by enterprising general practitioners. The ethical offence is the same whether committed in the West End square or the East End slum. In the case of the Finsen light treatment the facts of the case are such as to demand serious attention on the part of the medical profession and of the public. The success of the method in curing lupus is undeniable, but there is no scientific evidence either that the cure is permanent or that the results of that particular plan are better than those yielded by ordinary surgical treatment. On the other hand, the cost of the apparatus and of its administration are relatively enormous, to say nothing of the tedious nature of the process. On the whole it may pretty safely be prophesied that in a few years' time the Finsen method of the treatment of lupus will be a curiosity of medicine, just as many a therapeutic fashion has come and gone. Meanwhile the lay journalist finds material for much interesting "copy" from the complicated measures introduced by Finsen. At the same time, a matter that more nearly concerns our readers, the names of a certain number of physicians and surgeons are being noised abroad in connection with that treatment. Something of the same kind is being done in the therapeutic action of the X-rays, or rather of the focus tube from which the X-rays are emitted. There can be no doubt that the focus tube exercises a healing action upon lupus, certain forms of ulcer, and other affections of the skin. Here again, however, we are faced by the general consideration that similar beneficial results can be obtained equally well from ordinary treatment. That view of the position is confirmed by the attitude of the leading dermatologists, none of whom have seriously advocated the use of the X-ray tube in skin practice. On the other hand, we find a few medical men receiving wide newspaper notice on the score of their wonderful results with the X-rays in that class of case. Now and then, it may be well to add, some of these attempts, guided by more zeal than balanced knowledge, have resulted in serious injury to the patients. To sum up the position of the profession with regard to the light ray and so-called X-ray cures, it may be said that, for the time being, professional judgment is suspended as to their exact value, and that in the meantime it is derogatory to the medical profession as a whole, and to those medical men in particular whose names are publicly associated with those methods, that the therapeutic measures in question should receive notices in the public Press.

### THE PROPOSED NATIONAL JOURNAL OF OBSTETRICS AND GYNÆCOLOGY.

THE adjourned meeting, to elect a committee with a view to the foundation of a national journal devoted to midwifery and the diseases of women, and representative of Great Britain and Ireland,

together with the Colonies and Dependencies which complete the British Empire, will be held to-day under the presidency of Sir John Williams. Accordingly, it is of interest to ask ourselves what position will such a journal occupy, if it be founded? Questions of many kinds must occur to the minds of obstetricians and gynecologists with regard to its future. Is it required? Will it injuriously affect the interest of the various societies which already publish journals or transactions? What will be its scope? That a national journal devoted to obstetrics and gynecology is required, there is little room for doubt. Indeed it is curious that such a journal was not sooner started. But it must be a national, or rather an imperial, journal, carried out on the widest lines, well illustrated, and of large size. In fact, to take a phrase from our Transatlantic brethren, it must be a "big thing." If it is stunted in its youth, assuredly it will never get the necessary pabulum of subscriptions which it requires. A journal of gynecology and obstetrics which limits itself to the United Kingdom will have but a short life. A few years ago, such a journal might have been successful, when the newness of gynecology, and the consequent opportunities which this subject furnished for individual work were such as would have provided abundant material. Now, the newness has somewhat worn off, and the consequent yield of journalistic matter is diminished. But perhaps this in itself is an advantage. We do not want a journal in which the opinions of British gynecologists are repeated *ad nauseam*—opinions which in many cases can be readily foretold before they are uttered; but we do want a leavening up or down—as the case may be—of home opinions and doctrines by the introduction of the knowledge and opinions of our Colonial brethren. But will not such a journal interfere prejudicially with the interests of our British obstetrical and gynecological societies? There are two societies which publish Transactions, and there is one which publishes a quarterly journal. Do not these publications adequately meet the needs of the British gynecological and obstetrical world, and will not the proposed journal sap the strength of the societies by depriving them of their members? We do not think so for one moment. The proposed journal must, in our opinion, be an imperial one in order to succeed. The journal of the British Gynecological Society is devoted to the work of the Fellows of that Society, and its circulation is—save for a few copies—limited to the Fellows. It is a part of the Society, and Fellows and prospective Fellows will be no more drawn away from their actual or prospective allegiance by the fact that an Imperial journal of gynecology has been started, than are the Fellows of any medical or surgical society drawn away because there are great medical and surgical journals published. Men join a society in order to belong to that society and to take part in its debates, and not merely to obtain the published report of its proceedings, even if such a report

assumes the form of a journal. The interests of the other societies to which we have alluded—the London and the Edinburgh Obstetrical Societies—will be even less affected by the issue of the proposed journal than is the Gynecological Society, inasmuch as they publish their proceedings in the form of transactions. Consequently, we trust that *all* our British gynecological and obstetrical societies will join in furthering the establishment, and in ensuring the success of the proposed journal. No individual society can prevent the foundation of such a journal, but by withdrawing its aid and so depriving the journal of that universal support which is so necessary, it can make ultimate failure take the place of success. If the new journal goes abroad as the representative of only a section of British gynecologists and obstetricians, what hope has it of becoming truly Imperial? And upon this we lay special stress, the more truly imperial the new journal is, the less it will affect the interests of individual British societies; the more it is crippled by the lack of universal support, the more it will interfere with the interests of the societies. Space forbids us from writing more. One point we would strongly urge—that the promoters of the journal should take every step, as we believe they will take, to ensure that their journal shall be representative of the entire obstetrical and gynecological world of Great Britain and Ireland, and of our colonies and dependencies, and that if they find insuperable difficulties in the way of creating so universal a journal they will spare themselves the pain of originating a failure.

#### HERNIA OF THE URINARY BLADDER.

ONE of the commonest operations which the surgeon is called on to perform is that for the relief of inguinal hernia. As a rule no difficulty is experienced, and if the patient is in hospital the usual course is to supplement the primary operation by performing the radical cure. The operation, however, is not always one of election; it is not unfrequently one of urgency, to be performed under the most unfavourable conditions, and in a state of extreme physical prostration of the patient. To add to the difficulty it has, at times, to be done by a poor, artificial light, which is very unsuitable for making the necessary examination of the contents of the tumour. In such hernial tumours the surgeon must be prepared to meet any of the abdominal or pelvic viscera, or, indeed, almost all of them, as in the case of the distinguished patient of Cline and Cooper. One of the least frequently found of the viscera is the bladder, which is present in about one per cent. of such cases, according to Sjovall, and at all ages, from twelve months to eighty years. It is not easy to recognise the viscuseven in daylight and in artificial light the recognition is still more difficult. The experienced operator needs not to be told that the walls of the urinary bladder as seen in such a tumour may vary in thickness from that of the wall of the ileus to

that of the cardiac ventricle. A fold of peritoneum may completely or partially envelope the protruding part, or it may be wholly uncovered by peritoneum, but found adherent to a lipoma. A golden rule in such cases is to cut nothing until you know what it is. And although circumstances may require that the urinary bladder be incised—as it has been for a calculus—it is very seldom necessary to do so, and the neatest closure of an incised wound is not equal to the unwounded viscus. In all doubtful cases the diagnosis may be made by passing a catheter, and, if necessary, so raising and gently pressing the protruding part as to drive its contents into the bladder, and again passing the catheter, as recommended by Percivall Pott; there still remains the hypodermic syringe, by which fluid may be drawn off and tested. Before operation it is well to get the history of the case—in some of the recorded cases the patient found even when he had emptied his bladder a further flow of urine was caused by pressing on and raising the rupture. In Brodie's case urination was effected by lying down and raising the lower limbs and pressing on the sac, which extended almost to the knee. Petit's patient adopted a similar manoeuvre to empty his bladder. Sometimes these cysts became very large, in Clements' case pressure on the swelling produced two quarts of urine. In Percivall Pott's case and in Mr. E. S. O'Grady's the hernia was suddenly produced by violence. But this is exceptional, in the great majority of cases the protrusion of the viscus is gradually brought about, and not unfrequently the protruding part assumes an elongated form like to the appendix, for which it has been mistaken. This gradual formation of the cyst allows of the function of the viscus being carried on without any serious inconvenience to the patient, unless the cyst becomes very large, so much so that in many cases the condition has not been recognised until after death, as in the case reported in 1520 by Dom J. Sala, in which the patient had all the symptoms of stone in the bladder. The stone could never be felt by the sound, but was found after death in the bladder, which had formed a cystocele in the groin. Similar cases have been reported by Bertholin, Plateau, Bonet, Petit, Heny, Vardier, and others the majority of whom are quoted by Morgagni and by Vardier. Some few cases have recently been added which show the difficulty of recognising the urinary bladder when present. Dr. Cheesman's case (*Med. Rec.*), in which the conditions were such that he did not recognise that he had incised the bladder until he examined the sac after removal, and was disturbed to find attached firmly to it a disc of mucous membrane about as large as a silver dollar, and easily recognisable as bladder mucous membrane. In our last issue we published M. Racoviceano's two cases, one a case of femoral hernia, in which he avoided opening the viscus by confirming his diagnosis by a skilful use of the sound; and the other a case of inguinal hernia in a female. Both sexes are liable

to the condition, and it occurs at all ages. It is one of those complications of hernia which the operative surgeon must ever bear in mind. And in all doubtful cases it is advisable to utilise the hypodermic syringe for diagnosis. Where the invaginated portion of the bladder has become greatly elongated and is, if returned, likely to form a pouch in which urine may become stagnant and decompose, or form a calculus, it is good surgery to excise it.

### Notes on Current Topics.

#### Army Medical Service Committee.

SIR THORNLEY STOKER contributed an able letter to *The Times* last week on the scandalous manner in which the Irish medical schools have been denied representation on the Special Committee appointed to inquire into the working of the Army Medical Service. "Of eight gentlemen," says Sir Thornley Stoker, "who, exclusive of the President and Secretary, compose the Committee, five represent schools or licensing bodies in London, one in Scotland, and one in Ireland, the eighth being Surgeon-General Hooper, who presumably represents the Indian Medical Service." The member of the Committee who is named by Mr. Brodrick, specifically, as representing Ireland does so in virtue of as small a pretext as could be denoted by such a term. He is an Irish graduate, who attended the Galway Hospital in addition to Guy's Hospital, and who presumably has been in the Army Medical Service since he was qualified. His early connections seem to have been entirely about London. "While," says Sir Thornley Stoker in another part of his letter, "I have no doubt that he is a thoroughly capable officer, who will ably represent the Army Medical Department on this Committee, to speak of him as representing Irish schools with which he can have no connection save as a student, and not much then, is palpably absurd." What have the Irish schools done to deserve this slight? They have done what in all things Irish is a fatal bar to the receipt of justice in Government matters. They have been loyal to the Government, and have supplied them with candidates, and, what is more, with competent candidates, entirely out of proportion to the number of their students. It is a sad thing to have to write, but loyalty in Ireland does not pay—at least, if the Government can help it. The latter are so accustomed to the man and the Body in Ireland which is "agin the Government," that they have come to regard the man or the Body which is not in this blissful condition as lacking something morally or mentally, and, therefore, not to be the kind of person or thing to be encouraged. "In 1893"—we again quote from Sir Thornley Stoker's letter—"out of 891 officers 429 had Irish qualifications." "In 1896 the bulk of the Army Medical Department was composed of Irish graduates." At the present time 37 per cent. of the *personel* of the Army Medical Department are Irish graduates. And the return which has been made to the Irish schools for

furnishing these graduates is—that after many years one Irish examiner is elected, and that when a committee is appointed to investigate the causes which have led to, and the remedies for, the depopulation of the Service, one Irish representative is nominated, and he has no connection with any branch of the medical profession in Ireland—an Irish bull, as perpetrated by an Englishman, and one of the distinctly sterile genus. In addition to Sir Thornley Stoker's letter in *The Times*, we understand that the Irish Medical Schools have made strong representations to the Secretary of State for War, pointing to the importance of nominating a representative of these schools on the Committee. We hear that Mr. Brodrick has expressed his willingness to do so, if a representative can be suggested who will undertake to attend the meetings of the Committee regularly and that such a representative will be found in the person of Sir William Thomson. We do not know that there is any necessity to thank Mr. Brodrick for his concession, as it is one which will benefit the War Office more than it will benefit the Irish schools. Why the determination should require to be reached by the devious route of letters to the public Press, questions in Parliament, and letters from the Colleges to the Secretary of State would puzzle anyone outside the world of officialdom.

#### Diphtheria Antitoxin in Scarlet Fever.

DRS. WASHBOURN and Goodall, in their work on infectious diseases, published in 1896, gave it as their opinion that there are no known drugs that will either cut short an attack of scarlet fever, or, as has been alleged by some writers, prevent susceptible persons from being attacked. Referring to septic complications of this disease they mention that it is possible that the anti-streptococcal serum may be found to be beneficial. We now learn from the *Medical Record* of New York that Dr. C. H. Dalton, about two years ago accidentally discovered that diphtheria antitoxin is an excellent remedy in the treatment of scarlet fever, and it is further stated that later investigation proves that it is equally as efficacious in the prevention of this disease. Dr. Dalton seems to have been particularly impressed with the fact that after using antitoxin in a number of cases which were running a very severe course the malady assumed a mild form. Progress in therapeutics has advanced with such rapid strides that it is by no means safe to definitely deny the possibility of the usefulness of new measures. In this particular instance the difficulty of avoiding the contagion of scarlet fever is so widely recognised, and the liability to confuse the faucial affection in true diphtheria with the undoubted membranous formation that may be found in scarlet fever at once raises the question whether Dr. Dalton's cases might have been examples of patients suffering from the two infections. To arrive at a safe conclusion in this matter one would like to have the data recorded upon which Dr. Dalton founded his diagnosis,

because the "strawberry" tongue, for instance, met with in scarlet fever is also occasionally noticed in cases of diphtheria. Before the diphtheritic antitoxin, therefore, can be credited with this new virtue every care must be taken to eliminate all doubt as to whether the cases were really scarlet fever, and we would suggest that this can be done by the simple expedient of determining the nature of the infection by bacteriological examination.

#### Transfusion of Lambs Blood.

THE treatment of severe anæmia by transfusion is by no means a new idea, but the method has been recently improved upon by injecting the blood of lambs, which appears to be the least toxic for human beings, and certainly has the merit of being readily available. Improvement was obtained even in some cases of pulmonary tuberculosis, the patients gaining considerably in weight. According to Bier, in the *Munchener Med. Wochen*, the theory on which the treatment was founded is that the animal organism can accustom itself to very varied conditions. A man suffering from severe tuberculosis of both sacro-iliac synchondroses which had supplicated and broken through the skin in numerous places was given ascending doses of lamb's blood until 10 c.cm. had been injected. Smaller and smaller doses were then used, until it was found that only 1.5 c.cm. could be employed with safety. The general condition of this patient improved remarkably, and the suppuration almost entirely ceased. In four cases of lupus, all of which had been previously subjected to treatment without obvious benefit, remarkable improvement followed, but it is not possible as yet to say whether this gratifying result is permanent or only temporary. From the description of the cases it seems that the first effect of the injection was a general flushing of the face, and in the majority of the patients there was a desire to defæcate, and a large stool was usually expelled some time after the injection. Urticaria was sometimes noticed. In a large number an abnormal appetite was developed, and fever and chill, without any subjective signs of discomfort, accompanied the treatment. Most of the cases complained of a feeling of dryness in the mouth and exhibited severe thirst, symptoms which testify to some change in the physical character of the blood. The indications afforded by these experiments of Bier are certainly suggestive, and fuller details may stimulate other observers to confirm and extend the utility of his work.

#### The Executive Ability of Medical Men.

THE Governors of the National Hospital for the Paralysed and Epileptic have only lately announced that in future two of the medical staff shall have seats on the Board of Management of that institution, and this should to some extent be an answer to the narrow-minded outburst of prejudice in connection with the appointment of a physician on the

Board of the Lunacy Commission of the State of New York. There are some men in New York who apparently entertain the same opinion in regard to the executive capacity of medical men as that held and expressed by certain members of the Board of Management of the National Hospital for the Paralyzed and Epileptic, for we find the old familiar nonsense brought forward in New York that the education of physicians is such as not to fit them for the discharge of the executive duties incidental to membership of the Lunacy Commission, and they are alleged to be mentally contracted rather than expanded by their special education. It is almost absurd to have to argue this matter seriously, but a very good answer can be found in the disorganised condition of Bellevue Hospital which can be shown to be due to the want of medical control in the choice of the attendants. With proper medical control it would have been impossible for any such terrible state of affairs to have existed in the detention wards for the custody of insane persons or alcoholics picked up in the streets of New York. No medical man would have permitted unskilled persons without adequate instruction or proper supervision to have had the care of this most difficult and trying class of patients. It cannot be too clearly understood that no medical institution can permanently prosper whose Board of Management is excluded from the judiciously exercised influence of the medical staff.

#### The Parasitic Theory of Cancer.

THE results which have up to the present been recorded of the investigations and observations now being carried out point to the conclusion that the parasitic or infectious theory of cancer is the only one which in any way satisfies the requirements of the pathologist and the clinician. For a very long time past the relation of irritation and traumatism to cancer formation has been discussed, and modern medical literature abounds in references to the fact that malignant growths often follow local injuries and local irritations. Arguments by analogy can be adduced in favour of this parasitic hypothesis from the tumours in trees and plants which are so well known to botanists. These tumours, which are sometimes spoken of as tree cancers, are caused almost invariably by a species of infection entering from without by means of some laceration of the protective covering or bark of the tree. Mr. Jonathan Hutchinson has described how a certain fungus is apt to destroy fir trees on a large scale by inducing decay of the medulla of the wood. The condition affects the stem of the tree, which stops growing and dies, when it is found that the fungus growth has undergone decomposition not due to chemical action. In these cases there is often no traumatism to the bark to indicate the source of infection, but it is believed to enter near the roots through the agency of rodents such as rabbits. The rabbit burrows under the fir tree, nibbles the root, and thus exposes the abraded por-

tion to the action of the spores of fungi. A very curious point in connection with this fungus life in trees and plants is that it is capable, under certain circumstances, of exhibiting almost indefinite periods of latency. The recently published monograph by Max Schuler embodies powerful argument in favour of the view that cancer is due to an extrinsic cause, that is to say, has a parasitic infectious origin.

#### Tendon Transplantation.

THE great strength and preponderating influence of the flexors of the thigh contribute to make contracture of the knee a not uncommon affection, and an unfortunate circumstance which accompanies the trouble is that the condition is very intractable and often as painful as it is disabling. The principle of tendon transplantation which has proved itself so useful in other regions has been applied by Heusner to the knee-joint. According to the results published in the *Deut. Med. Woch.*, for May 30th, Heusner has succeeded in obtaining excellent functional results, the pain so frequently noticed in these cases of contracture being relieved, and the disabling deformity corrected. The muscles most available for the purpose are the biceps on the external side with the gracilis and semitendinosus on the inner side, and final success is more certain of attainment if the incisions through which the tendons are dissected out are made ample and carried half-way up the thigh so that the structures to be freed may be freely liberated from surrounding parts; after this they should be subcutaneously drawn into another incision in the patellar region through which they are sutured to the quadriceps tendon. This surgical procedure is evidently an operative method that has a wide sphere of usefulness in front of it, and will be sure to find many adherents.

#### Fatality at a Hypnotic Exhibition.

THERE is a large section of the public who flock to exhibitions by so-called "professors" of hypnotism, and sit through the usual disgusting performance of seeing the wretched "subjects" devour filth under the impresson that what they are eating is sweet and toothsome. We are glad to put on record that one of these "professors" has been put under arrest concerning the death of a "subject" who was lately killed during the performance of the feat of resting the head and the heels on the backs of two chairs with a 600lb. stone on the abdomen which it was pretended a blacksmith broke to pieces with a sledge-hammer. The cause of the fatality was the slipping of the chair away from the head of the "subject," who thus fell to the floor head first, and the stone, rolling on his head, crushed it. It must be obvious that this particular performance is characterised by fraud, and the stone which is apparently broken with such violence by the sledge-hammer of the blacksmith must, as a matter of fact, be previously broken up and cleverly pieced together for the purpose of deception. The only effective method of dealing with the debased curiosity

that finds pleasure and even mirth in the contemplation of the infirmities of these wretched "subjects," must be by educating people to a higher ethical standard, and this, unfortunately, is a long and uncertain process.

#### Undesirable Prosecutions.

UNLESS there be very good reason for suspecting deliberate evasion of the law on the part of medical practitioners in regard to the notification of infectious diseases, it is unquestionably bad policy to institute police proceedings for mere failure to notify. It is open to everyone to overlook the infectious nature of the illness, or it may be simple oversight. In the first event the law does not require a practitioner to do more than act to the best of his ability, and in the second it would, in most instances, be sufficient to warn the forgetful practitioner. These remarks are prompted by the report of some abortive proceedings brought against Dr. Harry Whittome, of Camberwell, for neglecting to notify a case of scarlet fever. The defence set up was that at the time there was no reason to suspect that the illness was of that nature, and eventually the summons was dismissed. Had the authorities taken the trouble to apply to Dr. Whittome for an explanation, no doubt a satisfactory one would have been forthcoming, and much vexation and trouble would have been obviated. We trust this and one or two other cases of a similar kind which have come before us within the last few days will impress upon sanitary authorities generally the fact that there is nothing to be gained and much to be lost by reckless prosecutions.

#### Reciprocity with Italy.

THE profession in Italy do not appear to have received the news of the step taken by the Privy Council in regard to the recognition of Italian practitioners in this country with the enthusiasm one might have expected. We must not, however, disguise the fact that the advantages of reciprocity are vastly in favour of British practitioners, so many of whom practise, or may be desirous of practising, in that country. Moreover, provided that there is *de facto* reciprocity, it matters little what the profession in Italy think of the matter. There is always, even in this land of liberty, a minority of narrow-minded persons who are unreservedly wedded to protectionism, though the application of these views to the practice of such a calling as medicine is absurd and indefensible.

#### False Teeth for Paupers.

THE plight of an elderly pauper whose teeth have "gone by the board," and who is thereby deprived of the ability to masticate the not over succulent food which boards of guardians supply, is one which may well appeal to the charitable. To ask that all the inmates of our workhouses whose denture is defective should be supplied with substitutes would be to add considerably to the burden under which ratepayers groan. Occasionally a compassionate board of guardians goes the length of

ordering a set for some specially deserving or unhappy inmate, and we note with sympathy and approval that the guardians of Abingdon have established a precedent in this direction. It would be more to the point if a scheme were devised whereby the aged and indigent poor could be supplied with artificial teeth by a local charitable agency working in concert with the dentists of the neighbourhood. A working set of teeth is almost as necessary as a wooden leg or a pessary, and fully as conducive to comfort and health. The inmates of workhouses do not exclusively belong to the worthless and improvident; they are but too often persons who are compelled by hard circumstances to wind up a life of unremitting toil in the chilling atmosphere of the poor-law, and they merit our compassion.

#### An Ineligible Antivaccinationist.

IN spite of all the influence that has been brought to bear, the Local Government Board has adhered to the view that an antivaccinationist is not eligible for the post of medical officer of health, and Dr. Scott Tebb's appointment stands annulled. Certainly, if there be one post more than another in which men with cranks would be out of place it is that of medical officer of health. He is brought into daily contact with the local practitioners, without whose cordial co-operation it would be quasi-impossible for him to fulfil his manifold duties, and there are plenty of sources of friction without importing one so peculiarly objectionable to the majority of medical men as a hostile attitude towards vaccination. Moreover, what would be such an officer's position in the event of an epidemic of small-pox? Would he sink his most cherished convictions and go in unblushingly for vaccination, or would he discourage the practice as far as he could? We do not want cranks in any department of public life, for wherever they are they lead to endless loss of time and temper by attaching undue importance to what are more often than not insignificant details.

#### Still More Penalising of the Medical Profession.

LAST week we drew the attention of our readers to a proposal by Sir Fortescue Flannery, M.P., to add a clause to the Factory and Workshop Acts Amendment Bill, whereby the medical attendant in a case of suspected anthrax shall be obliged to take a specimen of blood from the patient and send it for microscopical examination to some "bacteriological expert." We pointed out the heartless and extraordinary character of the proposal, to do this contrary to the wishes of the patient and his friends, with the patient possibly *in extremis* . . . the whole proceeding being useless so far as benefiting the patient or diagnosing his case. We trust that it will suffice to have called attention to the proposed enormity to ensure its rejection. We have now to record a further most objectionable proposal by Sir F. Flannery. He has proposed a clause in the same Bill to make it obligatory on the practitioner to notify any injury in-

curred in a factory or workshop. Here, again, we have the enforcement of penal obligation against medical men to work for the State, against which we protest. Moreover, the work here demanded is not professional work at all, for how can a medical man say where an injury was inflicted unless he was present? Must he take the word of the patient, and relying thereon sign a certificate that the man was injured in somebody's factory or workshop? The thing is too ridiculous, and Sir Fortescue Flannery is doing himself an ill service by proposing such impossible and useless amendments. Not the least offensive part of this amendment is Sir Fortescue Flannery's idea that medical men in performing this offensive task should be classed with every herbalist or impostor who may apply a piece of sticking plaster to a cut finger, which treatment would come under the surgical aid referred to in the clause. The quack and the medical man are alike referred to as under obligation to certify. We trust the profession will combine and once for all put a stop to these encroachments on the rights and privileges they should enjoy. It is certainly a hardship that the attempts to subject the profession to further indignities should be going on secretly in committee-rooms of the House, only to be discovered by accident.

#### The Housing of the Working Classes.

AN important discussion upon the housing question took place in the Commons in the course of the debate on the Vote for the Local Government Board. Several important points were brought forward. Perhaps one of the most striking was the fact that the London County Council charged from 5s. 6d. to 7s. 6d. a week for one room, from 8s. to 10s. for two rooms, and from 10s. to 12s. for three rooms. Rents of that kind are clearly prohibitive for the very poor, and show that there is some flaw in the present system. It was suggested in the House that the land values required drastic treatment, in answer to which Mr. Long answered on behalf of the Local Government Board that to treat land separately from buildings would require fresh legislation. That attitude is so far encouraging in that it recognises the need of some reform in the direction indicated. So, too, with the proposed extension of time for repayment of loans by local authorities. Mr. Long advanced certain principles of the utmost importance. As trustee for a posterity that could not be consulted, but would have to pay the bill if presented at a postponed date, he said that municipal Corporations would have to show the most rigid economy with regard to the purchase of land and the sufficiency of the buildings they erected. Other remarks of the right honourable gentleman revealed a hitherto unsuspected sympathy with advanced liberal opinion on this great social question. The extension of the period of repayment from fifty to one hundred years is regarded in the most diverse ways by different investigators. At the Ipswich meeting of the British Medical Association it was rejected by

vote of the State Medicine Section, on the ground, apparently, that any reduction of rent gained thereby would be too small to be of practical value. In the Commons Dr. Macnamara stated that the granting of the longest statutory period for repayment now permissible would enable the Council to reduce rents by 3d. or 4d. a week. The statutory limit of sixty years has been reduced in practice to forty by the Board, as against a proposed extension to 100 years, as in Prussia. The latter extension could not fail materially to reduce rents. It is really time that this point, which is capable of mathematical demonstration, should be settled definitely once for all.

#### A Judge on Doctors' Bills.

THE large percentage of bad debts made by medical men in general practice affords a striking testimony to the readiness with which they respond to the call of suffering. At the same time it testifies to the extreme unreadiness of a great majority of the public to recognise the value of services rendered by the payment of the fees that have been incurred on account of medical attendance. It is an undoubted fact, for instance, that many a busy medical man is unable to take a holiday because he cannot collect debts owing in many cases from folk who are ready to live up to their incomes in ways that do not fall under the heading of the necessaries of life. The sordid side of human nature is nowhere more grimly disclosed than in county court proceedings for the recovery of medical debts. In hearing such a case recently, Judge Owen, in a South Wales court, remarked to the defendant:—"The last person you think of paying is the doctor, and when you are ill you fall down and worship him, but when he sends in his bill you don't pay it." It would be well if this vigorous, if somewhat homely, criticism were circulated widely among the multitudinous class which seems to think that the maxim, "Virtue is its own reward," was specially framed to adjust the relations of patient and medical man.

#### More Arsenic in Liverpool Beer.

THE year 1900 should be marked with the blackest of letters in the annals of the brewing trade, for there can be little doubt that the disastrous outbreak of arsenical beer poisoning in the North of England has dealt a lasting blow against the popularity of beer. After all the outcry, the exposure of a long roll of injury and death, and the subsequent prolonged series of judicial prosecutions, it seems hardly credible that a Liverpool publican should still be selling arsenical beer. That such is the case, however, was proved a week or two ago before the local Stipendiary, who imposed a fine of £10 and £5 15s. 8d. costs upon a publican for the offence mentioned. The analyst at Somerset House found the incriminated beer to contain one-seventieth of a grain per gallon. The Stipendiary, Mr. Stewart, did not think the Act was intended to apply to a case of that kind, "where things had not been deliberately put in for the pur-



pose of making an inferior article equal to something it was not." With every sympathy for that legal opinion, we may perhaps be pardoned for congratulating the public that an Act of Parliament may sometimes protect their lives by departing from the intention of its framers. For a Liverpool publican to be still selling arsenic to his customers is simply to fly in the face of Providence.

#### The Contagiousness of Alopecia Areata.

THE contagiousness of that form of circumscribed baldness known as *alopecia areata* has long been the subject of discussion in dermatological circles. It has been obstinately denied by competent observers over and over again, in spite of the fact that it certainly tends to occur in epidemic form in regiments and schools. The obvious conclusion is that the divergence of opinion arises from the observations of the various investigators having borne on diseases similar in clinical appearance but differing in their pathological cause. The balance of skilled opinion at the present time appears to be in favour of a certain degree of contagiousness, but it is conceded to be unnecessary to insist upon the same stringent precautions as in the case of ringworm. It is sufficient in a general way to keep the infected areas covered with a dressing of some sort, and to avoid the promiscuous use of brushes, towels, &c. It is important that this view should be made generally known, because the affection is one, which runs an exceedingly protracted course and if isolation be insisted upon its successful treatment necessitates so prolonged an absence from school or factory as to cause much inconvenience and, it may be, suffering.

#### The Queen and the Nurses.

HER MAJESTY has always taken the keenest interest in nursing questions, and gladly avails herself of every opportunity to testify to her continued interest in the welfare of these handmaids of medical benevolence. On Friday last Her Majesty received a large number of members of the Royal National Pension Fund for Nurses at Marlborough House, to whom she presented their certificates of membership. Over a thousand nurses put in an appearance, and the weather being fine the reception was a great success, many of them affording, says the *Times* correspondent, ocular demonstration that the art of making millinery attractive is not incompatible with the practical requirements of a hospital costume.

#### Death of Miss Ormerod.

THE death of Miss Ormerod, the distinguished entomologist, deprives us of one of the most assiduous and devoted students of insect life, especially in its agricultural bearings. The deceased lady manifested a passion for the study from her earliest infancy, and the services which she has rendered to agriculture are quite inestimable. By the attentive study of their lives' history she was enabled to detect the insects which were responsible for the damage to crops, and to suggest means of circumscribing their

ravages. Miss Ormerod died, after a long and honourable career, on Friday last, from cancer of the liver, at her home at St. Albans.

#### The Congress on Tuberculosis.

THE labours of the Congress are now in progress. Already on Saturday the reception rooms at the Queen's Hall were thronged by applicants for registration, and again on Sunday crowds, largely composed of foreigners, besieged the offices. The labour of registration proceeded rapidly and smoothly, and each member was presented with a list of members and delegates, a programme of the proceedings, scientific and social, together with a bulky volume, being the descriptive catalogue of the Museum, reaching to close upon two hundred pages. On Monday the Congress was formally opened by H.R.H. the Duke of Cambridge at the request of His Majesty the King, at the first general meeting which took place at St. James's Hall, in the presence of a larger audience than the hall could conveniently hold. Yesterday (Tuesday) the sectional work commenced, and the second general meeting took place, when an address was delivered by Professor R. Koch, of Berlin. So far as numbers go the Congress bids fair to be a phenomenal success, and, judging from the titles of the papers, the discussions promise to be worthy of the occasion.

#### The Portrait Advertisement.

THERE exists a not unnatural confusion in the minds of the public between the General Medical Council and the British Medical Association. This is of some importance, because the two bodies occupy a very different position in regard to the profession. A clearer understanding of this fact would have cut short much correspondence and editorial comment in the lay press on the prohibition of medical men allowing their portraits to be published in lay journals, a practice which is eminently unethical. If it could be shown that the publication took place with the consent, or at the behest, of the practitioner, the Council might possibly have something to say to it; but as conclusive evidence of consent must necessarily be exceedingly difficult to obtain in such cases, the Council has, so far, taken no action.

#### Doctor v. Medical Guardian.

A NICE little problem is awaiting solution at the hands of the Newton Abbot Board of Guardians. It seems that Dr. Culross, the medical officer of the workhouse, has taken umbrage at the conduct of Dr. Ley, one of the guardians, who, he alleges, systematically inquires into the cases in the infirmary, and occasionally challenges the diagnosis and treatment, in the course of his visits as guardian. If such be really the case, Dr. Ley's conduct would be deserving of the gravest censure, and would, in fact, constitute a serious abuse of his position as guardian. The subject is under investigation, and we hope it will turn out that the allegations have no more serious basis than nurses' gossip.

### Traumatic Scarlatina.

THE occurrence of scarlet fever in a patient after an injury has suggested to Dr. Lippmann the possibility of the germs of infectious diseases lying latent in the organism ready to become active under certain circumstances. This is by no means a new theory, but the difficulty of proving conclusively that the case is *propter hoc* and not merely *post hoc* is practically insurmountable, and, moreover, the number of well-authenticated cases is far too limited to corroborate the theory, which is in opposition to all that we know concerning the genesis and natural history of such diseases.

THE King held an Investiture at Marlborough House on the 16th inst., when the honour of Knight Commander of the Royal Victorian Order was conferred upon the following gentlemen:—Sir Thomas Smith, Bart., F.R.C.S.Eng.; Deputy Surgeon-General Henry Julius Blanc, and Mr. William Henry Bennett, F.R.C.S.Eng. The following gentlemen were invested with the Insignia of Commanders of the Order:—Mr. Donald William Charles Hood, M.D., Cantab.; Mr. John Hammond Morgan, F.R.C.S. Eng., and Mr. Charles Arthur Morris, F.R.C.S.Eng.

AT the competitive examination held last month for sixty resident medical officers (*internes*) in the Paris hospitals, two of the successful candidates were women, Mesdemoiselles Arviset and Bonnet, both M.D. of Paris.

### PERSONAL.

MR. J. W. DOWDEN, M.B. C.M., F.R.C.S.Ed., has been appointed Assistant-Surgeon to the Edinburgh Royal Infirmary.

THE EARL OF DERBY will take the chair at the dinner to be given to the foreign vice-presidents and delegates to the Congress on Tuberculosis at the Hotel Cecil on the 26th inst.

SIR FRANCIS LAKING, Physician in Ordinary to the King, has been elected consulting physician, and Mr. T. Pickering Pick, F.R.C.S., consulting surgeon, to the Victoria Hospital for Children, Chelsea.

DR. J. J. B. MACLEOD, Demonstrator of Physiology in the London Hospital Medical College, has been awarded the Mackinnon Studentship by the Council of the Royal Society, for the purpose of enabling him to carry on researches in pathological chemistry.

ONE by one the many appointments held by the late Mr. Thos. Bond, F.R.C.S., are being filled, the last being by the Secretary of State, who has appointed Dr. John Norton, surgeon to the A Division of Metropolitan Police attached to Great Scotland Yard, Westminster.

MR. G. L. DRUCE, M.A., F.L.S., Mayor of Oxford, President of the British Pharmaceutical Society, will preside at the annual Conference, to be held this year in Dublin on the 29th, 30th, and 31st inst. The Lord Mayor of Dublin will welcome the members of the Conference, the meetings of which will be held in the rooms of the Royal Dublin Society.

### Scotland.

[FROM OUR OWN CORRESPONDENT.]

SLANDER ACTION AGAINST A GLASGOW DOCTOR.—A case presenting some very painful and even discreditable features has just been before the Court of Session in Edinburgh. A Mrs. Wallas, with consent of her husband, Joseph Wallas, jun., 72, Preston Street, Govanhill, Glasgow, raised an action against Dr. James W. Wallace, residing at 87, St. Andrews Drive, Pollokshields, for £500, as damages for alleged slander. The pursuer has a son, aged two years, who for a year had been under treatment by a Govanhill doctor. The defender in February last was consulted regarding the child's condition, and at his request he was repeatedly consulted. He informed the pursuer that the Govanhill doctor's diagnosis was wrong, and the treatment was, therefore, wrong, and had aggravated the child's ailment, and if continued the child would not long survive. Later on the defender informed the mother that he had seen and consulted with the Govanhill doctor, and had pointed out to him the errors in the treatment. He also informed her that the Govanhill doctor had often to make use of his assistance in difficult cases. The pursuer learned from the Govanhill doctor that the defender's statements were absolutely false, that he had no meeting with the defender, and that the defender had never been consulted by him in any case. Dr. Duncan, of the Victoria Infirmary, confirmed the diagnosis, and approved of the treatment carried out by the Govanhill doctor. The pursuer's statements were embodied in a declaration made before a Justice of the Peace, and the matter was then brought before a committee of the Southern Medical Society, of which both doctors were members. Before this was done an opportunity was given the defender of explaining his position. He then stated that the pursuer's declaration was false, and it is alleged he called her a liar, and made other statements relating to the pursuer and her family which were derogatory. In Court the defender's counsel asked that the reference to what had taken place before the committee of the Southern Medical Society should be struck from the record. The judge declined to do this, and rightly so. The case has been settled by the defender paying £101 and expenses. Evidence has not been led in this case, but the fact that the defender has tendered such a payment as the above would naturally lead one to infer that the serious allegations were in some measure at least true. That being so, the case is a very bad one indeed, and anything but creditable to the defender. It would be interesting to the profession at large to know what took place before the Committee of the Southern Medical Society. Without entering into detail, we venture to suggest, if such allegations are true, that it is perhaps the duty of a Society to ask for the resignation of a member who could be guilty of such conduct.

WILL OF DR. JAS. DUNLOP, OF GLASGOW.—The will of the late Dr. James Dunlop, 16, Carlton Place, Glasgow, has just been lodged with the Sheriff Clerk of Lanarkshire. It amounts to £20,849 16s. Dr. Dunlop, although well advanced in years, volunteered for active service in South Africa at the beginning of the war, and for some time was attached to the hospital at Wynberg. Soon after his return to Glasgow he began to complain, and died a few months ago.

### Scarlet Fever in Birmingham.

THE Health Committee of the Birmingham City Council are much disturbed by the serious prevalence of scarlet fever and additional accommodation is urgently required. For some weeks past the average weekly number of cases has been 238, with a weekly average in hospital of 344, that is to say, 100 more than the average for last year. It is unusual for scarlet fever to assume an epidemic form so early in the year, and the committee are not unnaturally anxious as to what will happen should the normal autumnal increase in the returns be superadded.

## Correspondence.

[We do not hold ourselves responsible for the opinions of our correspondents.]

## "HIGHER" DENTAL DEGREES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The announcement in your editorial notes to-day (July 17th) that the University of Birmingham has decided to institute a new degree to be styled "Bachelorship of Dental Surgery," will, I believe, come as a surprise to most of your readers practising in that speciality, and I venture to affirm that if those dental surgeons who have valid claim to speak with authority on professional questions could be polled an overwhelming majority would be found to agree with you in denouncing the step as unnecessary, uncalled for, and likely to prove as injurious to the dental branch as to the whole medical profession. The licence in dental surgery forms a first-rate special qualification. Students who have conscientiously worked through the curriculum and passed the examinations are probably better prepared for the pursuit of their calling than the votaries of other specialities for whom no special training is provided by the authorities, and who are left to their own devices.

Extra courses of anatomy, physiology, or other medical subjects will not make the dental licentiate one jot better as a practitioner, nor will a "higher" degree based on a little knowledge of that kind advance the "bachelor of dental surgery" in the estimation of his professional brethren. The first thing is to become an accomplished dentist. After that, if higher professional position is sought for, the proper course is to take degrees in arts, science, or medicine; and this is what an increasing number of dental candidates now strive for. A fair proportion of the younger generation of dentists are now graduates in arts or science of one or other university; and many of them hold medical or surgical qualifications. These are the "higher" degrees which are valuable to the individual in making him a broadly-educated professional man, standing in wealth of general culture and in special knowledge on a level with practitioners of other departments of medicine. This status he will not be able to claim from a degree of the kind described in your note. It is certainly astonishing that the University of Birmingham, which everybody has understood was to have been above all things a pattern of practical sound sense, should have lent itself to the promotion of a scheme so crude, so valueless, and even injurious.

I am, Sir, yours truly,

A PAST PRESIDENT ODONTOLOGICAL SOCIETY.

July 17th, 1901.

## THE CHELTENHAM MEETING.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I shall esteem it a favour if you will state in your next number that there will be a meeting of members of the B.M.A. interested in its reform, on Monday evening, July 29th, at 9 o'clock, at Cheltenham, to discuss the proposals of the Reconstitution Committee, notably with regard to co-optation by the Council, the Referendum, and Finance. The place of meeting will be duly announced by circular. The object is to decide upon the attitude to be adopted on presentation of the report to the annual general meeting.

I am, Sir, yours truly,

JAMES BRASSEY BRIERLEY.

Alma House, Old Trafford.

## A Chemist-Apothecary Fined.

MR. W. M. JENKINS, a chemist at St. Clears, Carmarthen, was fined £20 last week for practising as an apothecary. It was proved that he had examined patients and then prescribed for them, this having transpired at the inquest on one of his patients who had died. The defence was that he had charged for the medicine supplied and not for the advice, but this fiction did not find grace with the jury.

## Literary Notes and Gossip.

A NEW series of articles dealing with the practical side of microscopy, together with notes and queries, correspondence, and description of new apparatus are appearing each month in *Knowledge*, under the editorship of Mr. M. I. Cross, joint author of the well-known hand-book, "Modern Microscopy."

ANY announcement of a new work from the pen of so brilliant a surgeon as Prof. Mayo Robson is of interest to the profession. He has now in the press a work on "Diseases of the Stomach and their Surgical Treatment," in the production of which he has been assisted by Mr. B. G. A. Moynihan, F.R.C.S., Arris and Gale Lecturer on Surgery, Royal College of Surgeons. Messrs. Baillière, Tindall and Cox will be the publishers.

As previously noted in these columns, a proposal has been put forward having for its object the foundation of a new monthly *Journal of Obstetrics and Gynaecology*. A meeting was held last month in the rooms of the Medico-Chirurgical Society of London and adjourned until today (Wednesday) at 5 p.m., when it is proposed to elect a committee of "ways and means."

DR. SOLOMON SOLIS COHEN, A.M., M.D., Professor of Medicine and Therapeutics in the Philadelphia Polyclinic, is engaged in editing a "System of Physiologic Therapeutics" by American, English, French, and German authors. The work will be complete in eleven volumes, and will be published by Messrs. P. Blakiston's Son and Co., Philadelphia.

SACHS and Brooks think that much can be done to record the progress of cases of muscular dystrophy. They report several cases in the *American Journal of the Medical Sciences* for July, in which great benefit accrued from systematic muscular exercises. Scudder describes, in the same journal, a case of a supernumerary ureter ending blindly, causing acute abdominal symptoms in a child, aged twenty months. This is only the ninth recorded case.

THE new "Text-book of Military Hygiene," by Surgeon-Capt. Munson, is, we hear, attracting considerable attention in army medical circles. Founded as it is on modern warfare, and dealing fully with future requirements in connection therewith, it is necessarily of a revolutionary character when compared with the old standards. But the recent American-Spanish war and the present Boer conflict have punctuated inherent defects and made reforms necessary.

"THE Belfast Health Journal" is one of the latest aspirants for public favour, and it has gone the right way to secure it by giving an excellent series of articles on its speciality and numerous good illustrations, also for traits of worthy health pioneers and philanthropists, of whom Belfast contains many, some being of worldwide repute as generous donors and sagacious philanthropists. Our contemporary has commenced well, is deserving of success, and we have little doubt that it will be attained.

THERE are not many new books in medicine usually issued during the dead season, but the publication of another edition of Rose and Carless's "Surgery" has been rendered necessary because of the rapid disposal of the previous edition, for which reason also the new volume will be little more than a reprint, with corrections to date. New editions are also announced as ready in a few days of Mr. de Méric's "Syphilis and other Venereal Diseases," and of Dr. Macnaughton-Jones's "Practical Points in Gynaecology."

WE are reminded of the steady flight of time by the appearance of Vol. CXXIII. of "Braithwaite's Retrospect of Medicine." This last half-yearly volume is full of the usual interest, and no man who wishes to keep abreast o-

professional matters, whether general or special, can afford to be without this most trusty old friend upon his bookshelves. It is not too much to say that the whole series of volumes, ranging as it does over sixty years, contains the history of medical progress during that remarkable period of scientific progress and enlightenment. It is to be hoped that Braithwaite's will thrive vigorously into an age not less prolonged than that attributed to the wandering Jew of fable.

LITTLE that is new can be said by way of description of that attractive health resort, Carlsbad, sometimes termed the "Mecca of Europe," because of the thousands who journey there for the *healing waters* year after year. Apart from its attraction for invalids, the town, rising as it does in terraces among the pine and fir clad hills, is extremely picturesque and well deserving the encomiums passed on it by artists and travellers. To make it still better known to English folk the Municipality of Carlsbad have just issued a volume of about 200 pages, edited by Dr. Josef Ruff, which they present gratis to visitors, or will send on application to anyone intending to visit the spot. In this book will be found descriptive and pictorial accounts of the various springs, bathing establishments, excursions, travelling routes, hotels, expenses, &c., so that a little optical and mental labour is all that is necessary.

THE "Atlas of the Anatomy and Physiology of the Child," with explanatory text by D'Arcy Power, M.D. Oxon, F.R.C.S., displays, in the superimposed, pictorial form, the special features of child anatomy, in the manner which has long since become familiar to students of the well-known series published by Messrs. Baillière, Tindall and Cox. The text is evidently designed for popular consumption, and is written in simple, untechnical English, suitable for the purpose, and it would be well for future generations if the mothers of to-day could be induced to follow its teaching. Some people, probably the large majority, are satisfied with a remarkably small acquaintance with the details of their anatomy and the play of their functions, but there are others who yearn to know something of the wonderful organism of which they are the temporary possessors. To such this Atlas will be welcome, for with a minimum tax upon the intelligence it illustrates the mechanism and its component parts. At three shillings—the price thereof—such knowledge is now placed within the reach of all.

#### NEW BOOKS AND NEW EDITIONS.

The following has been received for review since the publication of our last monthly list:—

- BAILLIÈRE, TINDALL, AND COX** (Henrietta Street, Strand, London).  
 The Theory and Practice of Military Hygiene. By Surgeon-Capt. E. L. Munson, M.A., M.D. Pp. 971, with 8 plates and 400 engravings. Price 32s.  
 Manual of Public Health, Laboratory Work, and Food Inspection. By O. W. Andrews, M.B., M.R.C.S., D.P.H.Camb. Pp. 292. Price 7s. 6d. net.  
 The Commonwealth of Cells. By H. G. F. Spurrell, B.A. Oxon. Pp. 126. Price 2s. 6d.  
 An Atlas of the Anatomy and Physiology of the Child. By D'Arcy Power, M.B., F.R.C.S. Price 3s.  
**BALF, SONS, AND DANIELSON, LIMITED**, (London).  
 The Association of Inguinal Hernia with the Descent of the Testis. Bradshaw Lecture. December, 1900. By John Langton, F.R.C.S. Pp. 68. Price 5s.  
**CHURCHILL, J. AND A.** (Great Marlborough Street, London).  
 St. Thomas's Hospital Reports. Vol. xxviii. Price not stated.  
 Schoolboys' Special Immorality. By Maurice C. Hime, M.A., LL.D. Third Edition. Price 1s.  
 The Ophthalmoscope, a Manual for Students. Fourth Edition. By Gustavus Hartridge, F.R.C.S. Pp. 152. Price 4s. 6d.  
**CHARLES GRIFFIN AND CO** (London).  
 Outlines of Diseases of Women. By John Phillips, M.A., M.D. Cantab., F.R.C.P. Third Edition, revised. Pp. 280.  
**LEWIS, H. K.** (Gower Street, London).  
 Purulent Nasal Discharges: their Diagnosis and Treatment. By Herbert Tilley, M.D., &c. Price 4s.  
**MACMILLAN AND CO., LIMITED** (London).  
 Anæsthetics and their Administration. By Frederic W. Hewitt, M.D. Cantab. Second Edition. Pp. 528. Price 15s.  
**SCOTT, GREENWOOD AND CO.** (London).  
 Practical X-Ray Work. By Frank T. Addyman, B.Sc., F.I.C. Pp. 300, with 12 plates. Price 10s. 6d. net.

**SIMPKIN, MARSHALL, HAMILTON, KENT AND CO. LIMITED** (London).  
 The Half-yearly Retrospect of Medicine. Vol. 123. Edited by James Braithwaite, M.D. Lond., and E. F. Trevelyan, M.D. Lond., F.R.C.P. Pp. 467. Price 6s. 6d.

**SMITH, ELDER AND CO.** (London).

A Retrospect of Surgery during the Past Century. By John Poland, F.R.C.S. Pp. 97. Price 5s.

**S WAN, SONNENSCHNEIN AND CO., LIMITED** (London).

A Treatise on Plague. By Major Geo. S. Thomson, M.B., M.A.O. Roy. Univ. Irel. Pp. 299. Price 7s. 6d.

**WRIGHT AND CO.** (Bristol).

Golden Rules of Hygiene. By F. J. Waldo, M.A., M.D. Cantab. Pp. 69. Price 1s.

### Literature.

#### FREYER'S STRICTURE OF THE URETHRA. (a)

THE author of this volume states that it consists of a series of lectures which he delivered at the Medical Graduates' College and Polyclinic in November last, and that he has published them in book form at the suggestion of many of his hearers.

The book contains six lectures, three of which deal with stricture of the urethra and its treatment, and three with enlargement of the prostate and its treatment.

Mr. Freyer's method of dealing with his subject is clear and concise; every lecture shows that he has a thorough grasp of the practical side of what he is writing about, and the treatments advocated are those which have been thoroughly tested by himself and many others. Of course there are some few points which may not please everybody, such as his classification of strictures, his evident hankering after the malarial origin of many cases of urinary fever, and his advocacy of vasectomy in the treatment of severe forms of prostatic enlargement.

Very properly the author does not write his lectures to advocate any fads of his own, and the practitioner who treats his patients according to the directions given will treat them well, and the surgeon who reads these lectures will, when next lecturing his hospital class, give a clearer and more concise account of modern urethral surgery than he would if Mr. Freyer had not given us this very excellent little book.

#### WANKLYN'S ARSENIC. (b)

PROF. WANKLYN may well claim to have been a pioneer in the methods of chemical analysis, and although a veteran in the world of chemical literature his energy and enthusiasm is still unabated, as evidenced by this excellent and most timely little work, which, as the author indicates, "has been called forth by the recent mysterious epidemic of chronic arsenical poisoning in Manchester, Liverpool, and other towns in the North of England." The outbreak of peripheral neuritis and other manifestations of arsenical poisoning have very rightly attracted the attention of all sorts and conditions of men, but the medical and chemical aspects have given rise to much discussion and will afford matter for extensive investigation. A book, therefore, such as the present, is in every way opportune, and its perusal cannot but prove helpful and highly suggestive.

The chemistry of arsenic is first carefully dealt with, the characters of arsenic both in the free and metallic state, and also in the form of arsenious and arsenic acid, and their salts fully detailed, and interesting reference is, moreover, made to the organo-metallic compounds of arsenic and kakodylic acid and its salts.

The methods for the detection and measurement of arsenic are dealt with at length. Such various views

(a) "Stricture of the Urethra and Hypertrophy of the Prostate." By P. J. Freyer, M.A., M.D., M.Ch., Surgeon to St. Peter's Hospital, London, Lieut.-Colonel, Indian Medical Service (Retd.). London: Baillière, Tindall, and Cox. 1901. Demy 8 vo, pp. 115. 40 illustrations. Price 5s.

(b) "Arsenic." By J. Alfred Wanklyn, M.R.C.S., formerly Lecturer on Chemistry and Physics at St. George's Hospital, Professor of Chemistry in the London Institution. London: Kegan Paul, Trench, Trubner, and Co., Limited. 1901. Price 2s. 6d. Pp. 99.

have been promulgated respecting the most convenient test for the presence of arsenic in beer and such like compounds, that it is valuable to have a clear statement as to the exact character of the tests which have in ordinary work so long been relied on, but which in the special cases recently arisen seem to have been proved wanting. The original account of Marsh's method is here given, extending over some ten pages. Reinsch's test is also fully described, and its usefulness and limitations indicated. Unfortunately, Gutzeit's test is not described, although it has recently been shown to be particularly convenient and trustworthy. Particular attention is devoted to the testing of arsenic in special organo-metallic conditions when the ordinary tests fail, except such as involve destruction of organo-metallic compounds.

Professor Wanklyn advocates the employment of a red-heat, which, breaking up organo-metallic combinations, should always be employed where the formation of organo-metallic combinations is suspected. Full details are given of the author's method of dealing with suspected beer by his combustion method. The concluding chapter deals with "The Manchester Epidemic of Arsenical Poisoning, and the Lessons to be Learnt from It," and mainly consists in extracts from already published accounts, together with a strong condemnation of the method employed by Professor Delépine "to estimate approximately the quantity of the poison." The work is peculiarly timely, fairly comprehensive, based on wide and exceptional chemical experience, and interesting and attractive in style and general presentation. We heartily commend its consideration to all medical men and chemists having to deal with the still perplexing problems which arsenical contamination of food products have recently brought into such prominence.

#### LOCKWOOD'S APPENDICITIS. (a)

We have carefully read through the pages of this work and have derived a considerable amount of information on this important surgical subject. Whatever the reason is, appendicitis is a disease which appears to occur far more frequently nowadays than it did twenty years ago. At any rate, the affection is far more studied, and its conditions seem better understood and more quickly recognised, than it was in years gone by. The author enumerates the histories of eighty-three cases of appendicitis which came under his own personal observation, and as far as possible he has given the clinical history, morbid anatomy, and morbid histology of the cases in detail, and has then specifically commented on each individual case, as he states that it seems to him to be the only way by which to learn how to infer the morbid condition of the appendix from the clinical symptoms, and ultimately to place the treatment of appendicitis upon a scientific basis.

Mr. Lockwood divides his subject into twenty-one chapters and the work runs to 287 pp., including a very complete index. The last half-dozen chapters are very practical, and contain a vast amount of valuable information. We, therefore, strongly recommend this work to those operating surgeons particularly interested in appendicitis. The matter treated is well printed on good paper, and the book is neatly bound and reflects credit on the author and publishers alike.

#### A Surgical Oversight.

AN inquest was held a few days since at Bethnal Green on the body of a child, *et. 3*, who had sustained a wound of the cheek which was dressed at the North Eastern Hospital for Children. The wound became inflamed, and the child was certified to be suffering from erysipelas, but examination of the wound after death revealed the presence of a piece of wood which had not been detected when the wound was attended to. A verdict exonerating the medical officer from blame was returned.

(a) "Appendicitis, its Pathology and Surgery." By Charles Barrett Lockwood, F.R.C.S., Assistant Surgeon and Lecturer on Descriptive and Surgical Anatomy in St. Bartholomew's Hospital, &c. Pp. 287. Price 10s. net. Published by Macmillan and Co., London. 1901.

## Laboratory Notes.

### CHIVER'S CAMBRIDGE LEMONADE.

WE have submitted the Cambridge Lemonade which Messrs. Chivers and Son, Limited, are introducing this season to a critical chemical examination, and find it to consist of fine sugar crystals coated with the natural constituents of lemon juice, namely, the essential oil of lemons together with citric acid and a very small percentage of other organic acids usually found in lemons. We have verified the statement that it is free from any added acid. Lemonade prepared according to the directions given with each bottle affords a very refreshing and palatable summer beverage.

### ABREY'S EFFERVESCENT SALT.

ABREY'S Effervescent Salt is described as "an ideal laxative." On examination, we found it to be a skillfully granulated product, containing the usual saline constituents in due proportion. It has an agreeable acidulous taste, and, in doses of from one to two teaspoonfuls, procures an easy action of the bowels. Its palatableness will ensure its popularity with a large class of persons who object to nauseous salines, and are averse to drastic purgatives of vegetable origin.

### APOMORPHINE AND STRYCHNINE TABLOID.

MESSRS. BURROUGHS WELLCOME AND Co. have added to their list a tabloid containing apomorphine hydrochloride, gr.  $\frac{1}{16}$ , in association with strychnine hydrochloride, gr.  $\frac{1}{16}$ . This tabloid is intended for administration by the hypodermic method. The drawback hitherto attending the use of apomorphine, a drug possessed of useful therapeutical properties, has been the depression, sometimes very marked, which follows. Moreover, as it is not a very stable salt in solution, the latter requires to be freshly prepared. The association with strychnine effectively obviates the tendency to depression, and the tabloid form facilitates the preparation of a fresh, and therefore active solution. These tabloids are put up in tubes containing a dozen.

## Medical News.

### The Dublin Hospitals.

THE annual report of the Board of Superintendence of the Dublin hospitals has just been laid on the table of the House of Commons. It states that during the year ending March 31st., 1901, no culpable irregularity on the part of nurses or attendants was brought under the notice of the Board, nor had it any serious or well-founded complaint from the patients, while the members of the Board are gratified to speak with cordial approval of the work done in the Dublin hospitals. The opinion is advanced that the efficiency of these hospitals would be enhanced if more frequent visits were made by the Governors at irregular times. While the Board recognises that under existing circumstances it is not possible to exclude from hospital treatment patients who are not in a financial sense legitimate objects of charity, they feel that discrimination should be exercised to ensure that the funds provided for charitable relief should not be spent on persons who are competent to pay for such advantages. The Board are glad to observe that the medical staff of each hospital (with the exception of one) is now represented on the Governing Boards by some of its members. The Board again point out to the hospital authorities the importance of having properly qualified cooks to prepare invalid cooking for special cases. The report records a regret that in several hospitals scarcely sufficient care is bestowed on this subject, which is frequently even more important than the administration of medicine. The figures in the report show that on April 1st, 1900, there remained 921 patients in the hospitals which are under the supervision of the Board. The number admitted during the year was 11,601, making the whole number under treatment 12,522, of whom 11,611 left the wards either cured or relieved, or were discharged from other causes. The

deaths numbered 480. On March 31st last there were 911 patients under treatment. Exclusive of incurables the mortality was 3.93 per cent. on 11,118 cases, estimated on the numbers who were discharged, or who died, or whose cases had been treated to a termination. The total daily average number of beds occupied in the hospitals covered by this report was 946.05.

#### The Medico-Psychological Association.

The annual meeting commences on Thursday morning, July 25th, at Cork, and is at first occupied with the transaction of formal business. At 2 p.m. the annual meeting reassembles. The President for the ensuing year, Dr. Oscar T. Woods, will be introduced by the retiring President, Dr. Fletcher Beach, and the President deliver his Address, after which medals and prizes will be distributed. Following the President's Address papers will be read by John Carawell, L.R.C.P. Edin., L.F.P.S. Glasg. (Convener of Committee on Inebriates Corporation of Glasgow), "On the Working of the Inebriates Act"; Thomas Drapes, M.B., Medical Superintendent District Asylum, Ennisecorhy, Ireland, "Insanity and Phthisis"; J. Michael Nolan, L.R.C.P.I., M.P.C., Medical Superintendent District Asylum, Downpatrick, "Residual Lunatics and Recent Legislation"; F. W. Edridge-Green, M.D., F.R.C.S., Hatcheroff House, Hendon, London, N.W., "Evolution of the Colour Sense." E. D. O'Neill, L.R.C.P.I., Medical Superintendent the Asylum, Limerick, "The Superannuation Question—its Effect on Asylum Officials, with suggestions for further legislation on the subject." On Friday, July 26th, the meeting reassembles at 10 a.m., when the following papers will be read:—Professors Dixon and Bergin, "Stereoscopic Radiography." Joseph Shaw Bolton, M.D., B.S., B.Sc. Lond., Claybury Hall, Woodford Bridge, Essex, will give a lantern demonstration—"Gross Lesions of the Cerebrum"; George Revington, M.D., Univ. Dubl., M.P.C., Medical Superintendent Central Criminal Asylum, Dundrum, Ireland, will read a paper on "Mental Conditions Resulting in Homicide"; W. C. Sullivan, M.D., R.U.I., H.M. Prison, Pentonville, London, N., will read a paper entitled "Crime in General Paralytics"; 2 p.m.—John Keay, M.B., Medical Superintendent District Asylum, Inverness, will initiate a discussion—"On the Care of the Insane at Night"; A. R. Urquhart, M.D., F.R.C.P.E., Physician Superintendent James Murray's Royal Asylum, Perth, will read a paper on "Effect Upon Patients of Changes of Asylums"; Daniel F. Rambaut, M.D., Univ. Dubl., Assistant Medical Officer and Pathologist Richmond District Asylum, Dublin, will read a paper entitled "A Case of Cerebral Hemiatrophy"; R. E. Leeper, F.R.C.S.I., Resident Physician, St. Patrick's Hospital, Dublin, will read a paper entitled "Three Cases of Melancholia presenting Symptoms of Unusual Clinical Interest," and he will show microscopic specimens and photographs. The President, Dr. Oscar T. Woods, and Mrs. Oscar Woods will be "At Home" to members and their friends on Friday, July 26th, from four to seven o'clock, at the District Asylum, Cork. Saturday, July 27th, an excursion has been arranged to Killarney. The annual dinner will take place at the Imperial Hotel, Cork, on Thursday, July 25th, at 8 p.m.; tickets, £1 ls. each.

#### Fete of Messrs. Burroughs Wellcome and Co.

The annual gala of the employes of Messrs. Burroughs Wellcome and Co. took place on Saturday last, in the spacious grounds attached to the factory at Dartford. Athletic and aquatic sports were carried on from 11 o'clock in the morning until dark, when the grounds were illuminated. Luncheon was served to over 1,000 employes in a spacious marquee, which gives one an idea of the enormous growth of the drug trade and accessories connected with this firm. The present occasion was made additionally interesting by the presence of Mrs. Wellcome, daughter of Dr. Barnardo, of Surbiton, the newly-made bride of the principal, the toast of prosperity to the firm and happiness to the newly-wedded pair being proposed in felicitous terms by Mr. Passmore Edwards, and drunk with enthusiasm. Mrs. Wellcome subsequently presented the prizes at the conclusion of the sports, and during the day there was an exhibition

of relics and photographs from Omdurman and other parts of the Soudan, collected during the past winter by Mr. Wellcome, which attracted considerable attention.

#### Summer Trains de Luxe for the Holidays.

The International Sleeping Car Company issues its programme of trains *de luxe* services, composed of sleeping and restaurant cars only, for the present season. The Engadine Express runs daily *via* Calais to Sargans, Ragaz, and Coire, in connection with the 11.0 a.m. train from Victoria and Charing Cross. A section of this train runs through to Lucerne on Tuesdays, Wednesdays, Fridays, Saturdays, and Sundays. Another section runs through to Berne and Interlaken on Mondays and Thursdays. The Ostend-Swiss Express runs daily *via* Ostend to Bâle, and Lucerne in connection with the 10.0 a.m. train from Charing Cross and Victoria. The Carlsbad Express runs daily to Nuremberg, Eger, and Carlsbad, *via* Ostend, in connection with the 10.0 a.m. train from Charing Cross and Victoria. On Wednesdays and Saturdays only, passengers by this train may leave London by the 11.0 a.m. train, and travel *via* Calais.

#### Royal College of Surgeons, Ireland.

The following is a list of Scholarships and prizes awarded for the Summer Session, 1901:—Carmichael Scholarship, £15: W. E. Ormsby. Mayne Scholarship, £15: J. P. Byrne. Gold and Silver Medals in Operative Surgery: Gold Medal, C. W. Ewing; Silver Medal, A. Charles. Stoney Memorial Gold Medal in Anatomy: R. W. Burkitt. Practical Histology: A. N. Cawford, first prize, £3, and medal; J. S. Sheill, second prize, £1, and certificate. Practical Chemistry: E. J. Clarke, first prize, £3, and medal; J. M. Hayes, second prize, £1, and certificate; Public Health and Forensic Medicine: Miss J. C. Hargrave, first prize, £3, and medal; S. B. Hanbury, second prize, £1, and certificate. *Materia Medica*: J. S. Sheill, first prize, £3, and medal; J. M'Quillan, second prize, £1, and certificate. Practical Pharmacy: Miss C. O'Meara, first prize, £3, and medal; J. M. Aloor, second prize, £1, and certificate. Biology: R. Bury, first prize, £3, and medal; F. X. Costello, second prize, £1, and certificate. The Schools of Surgery will resume work after the summer recess on Tuesday, October 1st.

#### The New Physiological Laboratory for Edinburgh.

On Saturday last the new physiological laboratory which has been built by Mrs. Cox in memory of her father, the late Professor John Hughes Bennett, M.D., F.R.S., was formally handed over to the University in the presence of a brilliant academic gathering. Sir William Muir, the Principal, presided, and among the members of the University and others who were present were Sir J. Burdon Sanderson, Sir J. Batty Tuke, M.P., Sir James Crichton Browne, Sir William Turner, Sir William Gairdner, Sir Henry Littlejohn, Sir Ludovic Grant, Professors Chiene, Simpson, Stockman, Schafer, Boyce, &c. Apologies for absence were received, among others, from Lord Lister and Sir Michael Foster. The laboratory is designed for the teaching of experimental physiology, and consists of two rooms—one fitted with all the apparatus necessary for practical work by individual students, the other a small theatre where the lecturers may give demonstrations to a class. After the opening ceremony, Sir J. Burdon Sanderson delivered an address on the life and work of Dr. Hughes Bennett.

#### Vital Statistics.

The deaths registered in the week ending July 13th, in 36 large towns of Great Britain and Ireland corresponded to an annual rate of 15.6 per 1,000 of their aggregate population, which is estimated at 11,463,026 persons in the middle of this year:—

Birkenhead 26, Birmingham 17, Blackburn 12, Bolton 17, Bradford 15, Brighton 13, Bristol 10, Burnley 15, Cardiff 12, Croydon 10, Derby 10, Dublin 21, Edinburgh 15, Glasgow 17, Gateshead 18, Halifax 9, Huddersfield 15, Hull 11, Leeds 18, Leicester 10, Liverpool 25, London 14, Manchester 17, Newcastle-on-Tyne 19, Norwich 13, Nottingham 15, Oldham 13, Plymouth 10, Portsmouth 20, Preston 21, Salford 19, Sheffield 14, Sunderland 18, Swansea 16, West Ham 14, Wolverhampton 13. The

highest annual death-rates per 1,000 living, as measured by last week's mortality, were:—From measles, 2·3 in Birkenhead; from whooping-cough, 1·1 in Swansea and 1·3 in Bradford; and from diarrhoeal diseases, 2·2 in Portsmouth and in Leeds, 2·3 in Preston, 2·9 in Sheffield, 6·0 in Liverpool, and 6·6 in Birkenhead. In none of the large towns did the death-rate from scarlet fever or from "fever" reach 1·0 per 1,000. The 66 deaths from diphtheria included 24 in London, 6 in Liverpool, 5 in Manchester, 4 in Leicester, 4 in Leeds, 3 each in West Ham, Cardiff, Salford, and Sheffield. One death from small-pox was registered in Liverpool, one in Glasgow, but not one in any other of the large towns.

**Lotus Arabeticus.**

TRADITIONALLY the lotus has a sinister reputation; and in practice the military and civil authorities in Egypt have found that it is highly poisonous in certain stages of its growth to the horses, sheep, and goats for whom it has been used as fodder. Some time back investigations were undertaken by Mr. Wyndham Dunstan, F.R.S., and Mr. T. R. Henry to discover the poisonous element in the Egyptian lotus—*Lotus Arabeticus*, and they found that its poisonous constituents included prussic acid. The poisonous property of the lotus appears to be due to the action of an enzyme, lotase, on a glucoside, lotusin, which breaks up into prussic acid and other constituents. The amount of prussic acid given by the plant differs according to the stage of its growth. The formation of the poison seems to reach its maximum at about the seeding period, and after that to diminish rapidly. The Arabs are aware that the plant itself is safe to use as a fodder when the seeds are quite ripe, but not before. During the ripening of the seeds the lotusin which contains the prussic acid disappears.

**Friedenheim Hospital.**

AN influentially signed appeal has been issued on behalf of the "Home for the Dying" at Swiss Cottage, the present financial position whereof is very precarious. Additional accommodation for the nursing staff is urgently required, and the building itself is in great need of repairs.

THE Society for the Study of Disease in Children has recently held a most successful provincial meeting at Liverpool. Although the association is still in its infancy, no less than seventy-three members attended the gathering. The programme included a number of papers on practical subjects connected with pediatrics, some of them being of a conspicuously advanced and scientific nature. There was the usual dinner, held in this case at the Adelphi Hotel, under the presidency of Dr. Ernest Sansom. Several excursions were organised and it may safely be said that the problem of how to get over the most ground within a limited time could hardly have been more conclusively answered. The Honorary Secretary of this most energetic society is Mr. Sydney Stephenson, who will be pleased to furnish any required information as to its scope and organisation. The next provincial meeting is to take place at Manchester in June, 1902.

**"Jelly a la Lemco."**

If our readers want an excellent and very nourishing jelly we should recommend the following:—Put into a stewpan one quart of cold water or veal stock, the rind of half a lemon, four cloves, a dessertspoonful of salt, half a teaspoonful of peppercorns, a dessertspoonful of tarragon vinegar, a small onion, a sprig of parsley, 2 ozs. of leaf gelatine and the well-beaten whites and shells of three eggs. Let all this come to the boil, the scum rising to the top, then draw aside the pan and cover it for five minutes. Pour a little boiling water through a jelly bag and then strain the jelly through it and add a teaspoonful of Lemco.

**Glasgow University Medical Passes.**

THE following have passed the fourth (final) professional examination in medicine at Glasgow University: For M.B., C.M.—Duncan Davie, William Henry Ferran, Shushil Kumar Roy, John Poynter Small, David Wallace Smith.

For M.B., Ch.B.—Martha Adams, John Anderson.

Thomas Anderson, William Archibald, James O. Barclay, John S. Barr, William H. Brown, William M. Brown, George Frederick Buchan, Ernest C. Burnett, Patrick T. Cairns, Samuel J. Cameron, Robert D. Campbell, James B. W. Cook, Ernest H. Cramb, Andrew Currie, David B. Davidson, James Davidson, M.A., G. H. G. Davie, Alexander Doig, Reginald N. Dunlop, George B. Eadie, William Elder, William W. Farrar, John Forrest, John A. Garden, Andrew P. Granger, John Gregor, George P. Harlane, Francis J. Henry, Douglas W. Hunter, Matthew Hunter, William J. Isbister, Thomas H. Jack, Daniel E. Kilpatrick, David Kyle, M.A., John Lambie, F. J. Lochrane, James W. M'Dougall, Thomas M'Learen, Hugh A. M'Lean, George W. M'Millan, James M'Pherson, M.A., Edward Magoveny, Jacob Mains, James G. Miller, Robert H. Mills, William A. Milne, Samuel J. Moore, Alan H. Muir, Robert Paterson, John Paton, James K. Patrick, Robert Ramsay, Peter M. Reid, William Robertson (Kilmarnock), Thomas R. Rodger, Charles J. Ross, B.A., David Shannon, Donald Steel, John Strathearn, Alexander D. Thompson, James Nathaniel Todd, Joseph G. Tankinson, John W. Turner, Robert W. Valentine, Albert E. Wainwright, James Walker, George S. Wallace, Peter M. Waugh, W. W. W. Wilson, Martha Adams, Mabel Hardie, Alice Moorhouse, Mary J. Pirret, Agnes B. Sloan, Elizabeth M. Sloan.

The following attained distinction. S. indicates surgery and clinical surgery; P. practice of medicine and clinical medicine; M. midwifery:—

John Anderson (P), William Archibald (P), Robert Wellwood Auld (P), James Oastler Barclay (P), John Stoddart Barr (P), William Herbert Brown (P), William Macalister Brown (P), George Frederick Buchan (P) Samuel James Cameron (PM), Edward Seymour Chapman (P), David Beattie Davidson (P), James Davidson, M.A. (PM), Reginald Nairn Dunlop (M), Janet Bissland Higgins (P), Douglas William Hunter (P), David Kyle M.A. (SP), James M'Pherson, M.A. (P), Edward Magoveny (SP), Jacob Mains (P), William Alexander Milne (P), Alice Moorhouse (P), Alan Howie Muir (P), Robert Ramsey (M), Peter Mackenzie Reid (P), William Robertson, Kilmarnock (P), Agnes Benkier Sloan (P), Donald Steel (S), Alexander Dey Thompson (SPM), Joseph Goodwin Tomkinson (P), Robert Warden Valentine (M), Albert Ernest Wainwright (P), James Walker (PM).

**Society of Apothecaries of London, July, 1901.**

THE following candidates have passed:—Surgery.—C. H. Allan, Sections I. and II.; A. G. H. Anthonisz; Section I.; F. A. Beattie, Sections I. and II.; P. C. Burgees, Section I.; C. E. C. Child, Section I.; T. J. M. Clapperton, Sections I. and II.; E. A. Dunn, Section II.; J. P. E. Henery; H. C. Hocken, Section II.; C. E. A. Huddart, Sections I. and II.; R. L. Jones, Sections I. and II.; F. P. Joscelyne, Section II.; C. C. Morgan, Section I.; B. E. Sansom, Section II.; C. V. Smith; P. P. Tobit, Section I.; F. I. Trimmer, Sections I. and II.; A. G. Wilson, Sections I. and II.; E. Yoxall, Section I.

Medicine.—F. A. Beattie, Sections I. and II.; J. E. Bolton, Section I.; G. M. Crockett, Section I.; K. A. Dawson, Section I.; E. A. Dunn, Section II.; H. C. Hocken, Sections I. and II.; F. P. Joscelyne, Section II.; A. E. Malaher; M. E. Martin, Section I.; E. S. Perkins; H. Richardson, Sections I. and II.; P. G. Sheppard, Sections I. and II.; J. E. Skey, Section I.; A. G. Wilson, Sections I. and II.

Forensic Medicine.—F. A. Beattie, J. E. Bolton, G. M. Crockett, K. A. Dawson, E. H. Forjett, C. J. Francis, H. C. Hocken, M. E. Martin, E. S. Perkins, F. P. Rose, J. E. Skey, and A. G. Wilson.

Midwifery.—F. A. Beattie, F. G. Bennett, F. J. Birks, P. J. R. Bucknill, W. V. Braddon, A. N. Collier, W. H. Crossley, W. R. Davies, C. W. Gibson, J. M. King, E. A. Le Maistre, D. E. Lockwood, M. B. Oliver, J. A. W. Webster, A. G. Wilson.

The L.S.A. diploma of the Society was granted to the following candidates, entitling them to practise medicine, surgery, and midwifery.—F. A. Beattie, F. J. Birks, P. J. R. Bucknill, E. A. Dunn, H. C. Hocken, F. P. Joscelyne, A. E. Malaher, C. V. Smith, and A. G. Wilson.

## Notices to Correspondents, Short Letters, &c.

**✉** CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

**REPRINTS.**—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the publisher or printer before the type has been distributed. This should be done when returning corrected proofs.

### TRAINED MEN FOR THE ARMY MEDICAL CORPS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The following official information has been sent us for publication:—"Trained men are required for the Royal Army Medical Corps for one year's service or the duration of the war. Full particulars can be obtained from the Chief Recruiting Staff Officer, St. George's Barracks, London, W.C."

G. F. DAVIDSON, Colonel.  
Chief Recruiting Staff Officer.

St. George's Barracks, London, W.C.,  
July 22nd, 1901.

Mrs. S. G. M.—You had better apply to a local medical man who may be willing to impart the necessary instruction in return for your daughter's services. It would, however, be better for her to prepare for the "minor" qualification of the Pharmaceutical Society, information respecting which can be obtained at the Offices, Bloomsbury Square, W.C.

X. V.—We shall be pleased to publish the case if you will forward us the details. It ought not to be difficult to veil the identity of the patient sufficiently to set all qualms at rest.

N. Y.—The subject of your article is well worthy of consideration, but the data upon which your sweeping strictures are based do not appear to us to warrant so much declamation. The matter is of purely scientific interest, and should be approached in a scientific spirit, leaving individuals out of the question. We are unable to make use of it as it stands.

Dr. M.—Such visits are purely a matter of courtesy, and you have no right to feel aggrieved if they are not made. It is highly undesirable to make every little social omission a pretext for cultivating ill-will both in your interest and in that of the newcomer.

Dr. POUJET.—We have no knowledge of the anti-tuberculous treatment in question. There are many "on the market," all equally untrustworthy. You would hardly be justified in experimenting with a "serum" until you had taken steps to ascertain its precise nature and effects, and this you should proceed to do. Your patient's wish does not exonerate you from all responsibility, as you seem to imagine.

## Diary for the Week.

### ENGLAND.

Daily this week, the Congress on Tuberculosis at the Queen's Hall, London.

FRIDAY, JULY 26TH.

SOCIETY FOR THE STUDY OF DISEASES IN CHILDREN.—Annual meeting at 11 Chandos St., London, W., 5.30 p.m.: Presentation of Report and Election of Officers.

TUESDAY, JULY 30TH TO FRIDAY, AUGUST 2ND.

BRITISH MEDICAL ASSOCIATION Annual meeting to be held this year at Cheltenham. First general meeting Tuesday, at 2.30 p.m. Sectional and general meetings daily. On Saturday, excursion to Wye Valley.

### IRELAND.

THURSDAY, JULY 25TH, AND FRIDAY, JULY 26TH.

MEDICO-PSYCHOLOGICAL ASSOCIATION OF GREAT BRITAIN AND IRELAND.—Annual meeting to be held this year at Cork. Hours of meeting, 10 a.m. and 2 p.m.

MONDAY, JULY 29TH, TUESDAY, JULY 30TH, WEDNESDAY, JULY 31ST.

BRITISH PHARMACEUTICAL CONFERENCE, to be held this year in Dublin. Sessions of Conference in Lecture Theatre, Royal Dublin Society, 10 a.m. to 1 p.m. and 2 p.m. to 4 p.m. each day.

## Appointments.

CARGILL, L. VERNON, F.R.C.S.Eng., L.R.C.P.Lond., L.S.A., Surgeon to the Royal Eye Hospital, Southwark.  
DUNLEA, M. P., M.D., B.U.I., Certifying Surgeon for the Riverstown District in the County of Cork.  
FAGAN, P. J., L.R.C.P.Irel., Lecturer on Elementary Physics in the Catholic University Medical School, Dublin.  
HAMILTON, W. M., M.D., R.U.I., Medical Officer of Health of Eccles Municipal Borough.  
HAYES, W. B., M.D., R.U.I., Certifying Surgeon for the Union of Tralee, in the County of Kerry.  
HOGG, J. A., M.B.C.S.Eng., L.R.C.P.Lond., Medical Officer of Health of Shardlow Rural Sanitary District.  
MASON, J. J., L.R.C.P.Édin., L.R.C.S.Édin., Medical Officer of Health of Bollington Urban Sanitary District.  
MADDEVER, J. C., M.D.Glasg., Certifying Surgeon for the Brownhills and Aldridge District of Staffordshire.

McCLIMARY, G. F., M.B.Camb., L.S.A., Medical Officer of Health of Battersea Metropolitan Borough.  
MEACHEN, G. NORMAN, M.B., B.S.Lond., M.R.C.P.Édin., M.B.C.S., Clinical Assistant to the Hospital for Diseases of the Skin, Blackfriars.  
MILLARD, C. K., M.D.Édin., Medical Officer of Health of Leicester County Borough.  
MUIRHEAD, JAMES, M.B., B.S.Durb., Senior House Physician to the Royal Infirmary, Newcastle-on-Tyne.  
O'BRIEN, D. J., L.R.C.P., L.R.C.S., Certifying Surgeon for the Darrow Dispensary District, Queen's County.  
PRITCHARD, W. G., L.B.C.P., L.R.C.S., Certifying Surgeon for the Bethesda District of the County of Carnarvon.  
ROUTH AMAND, M.D., B.S., F.R.C.P.Lond., Consulting Physician to the Samaritan Free Hospital for Women, London.  
TREDNICK, A. S., L.R.C.P.Lond., M.B.C.S.Eng., Certifying Surgeon for the Melbourne District of Derbyshire.

## Vacancies.

Blackpool Corporation.—Medical Officer of Health for the Borough. Salary £400, rising to £500 per annum. Age not to exceed 50 years. Candidates must devote his whole time to the duties. Forms of application to be obtained from the Town Clerk. (See Advt.)  
Cumberland and Westmorland Asylum, Garlands, Carlisle.—Senior Assistant Medical Officer, unmarried. Salary £150 a year, rising to £180, with board, lodging, &c.  
Devon County Asylum, Exminster, near Exeter.—Third Assistant Medical Officer. Salary £125, rising to £150, with board, lodging, &c. Applications to the Medical Superintendent.  
Halifax Union Hospital, Salterhebble.—Resident Medical Officer. Salary £140 per annum, with apartments, rations, and washing.  
Hospital for Sick Children, Newcastle-on-Tyne.—Resident Medical Officer. Salary £100, with board, lodgings, and laundry.  
London Hospital, Whitechapel, E.—Assistant Director of the Pathological Institute. Salary £200 per annum.  
North Wales Counties Lunatic Asylum, Denbigh.—Second Assistant Medical Officer. £120 per annum, increasing to £160, with board, residence, and washing.  
Nottingham General Dispensary.—Two Assistant Resident Surgeons, unmarried. Salaries £160 per annum each, increasing by £10 every year, with furnished apartments, attendance, light, and fuel.  
Royal Cornwall Infirmary.—House Surgeon, unmarried. Salary £100, increasing by £10 a year, with board (excluding stimulants) and apartments.  
Rural District Council of Bishop Auckland.—Medical Officer of Health for the Rural District. Salary £350 per annum. Whole time to be devoted to the office. Applications to the Clerk of the Council, Bishop Auckland.  
St. Matthew, Bethnal Green Infirmary, Cambridge Road, N.E.—First Assistant Medical Officer, unmarried. Salary £150 per annum, with board, lodging, and laundry.  
University of Sydney, New South Wales.—Professor of Pathology. Salary £900 per annum. Pension £400 per annum after twenty years' service. £100 allowed for passage. Further particulars of the Agent-General for New South Wales, 9, Victoria Street, London, S.W.  
Wolverhampton and Staffordshire General Hospital.—Assistant House Physician for six months. Honorarium at rate of £75 per annum, with board, lodging, and washing. Also Assistant House Surgeon for six months; same honorarium.

## Births.

BENNETT.—On July 19th, at 33 Vancouver Road, Forest Hill, S.E., the wife of Colin E. Bennett, L.R.C.P., M.B.C.S.Eng., of a son.  
MERRY.—On July 21st, at 2 Chiswick Place, Eastbourne, the wife of W. J. C. Merry, M.D., of a son.  
SKINNER.—On July 17th, at Bank House, Rye, Sussex, the wife of Ernest W. Skinner, M.D., of a daughter.  
WHITE.—On July 16th, at the Dover House, Bigbrooke, Northamptonshire, the wife of Percy Stanhope White, M.B.C.S., L.R.C.P.Lond., of a daughter.

## Marriages.

GERVIS.—Old.—On July 18th, at St. Augustine's Church, Kilburn Arthur Frederick Gervis, M.B.C.S., L.R.C.P., of No. 1 Steele's Road, Hampstead, son of Frederick H. Gervis, M.B.C.S., to Ethel, eldest daughter of Charles Old, of Brondesbury.  
MISKIN.—MISKIN.—On July 20th, at the Parish Church, Eltham, Kent, Ernest Miskin, M.B., M.B.C.S., L.R.C.P., son of Dr. Miskin, of Slade House, Kennington, to Mabel Caroline, only daughter of W. P. Miskin, Eltham, Kent.

## Deaths.

BEGG.—At Hout Kop, near Vereeniging, on July 11th, Charles Begg, aged 21, killed in action, eldest son of Charles Begg, M.B., C.M.Édin., of Bath.  
MIDDLETON.—On July 20th, at the Royal Infirmary, Preston, Basil Charles Middleton, M.B., Ch.B., eldest son of Charles E. Middleton, Adlington, Lancs., aged 25 years.  
NEALE.—On July 16th, at London Road, Leicester, John Headley Neale, M.B.Édin., M.B.C.P.Lond., aged 51 years.  
PEARSE.—On July 19th, at the Bookery, Blofield, Arthur Pearse, M.D.—formerly of Botesdale, Suffolk, aged 64 years.  
BIGGS.—On July 12th, John Arthur Biggs, M.B.C.S.Eng., L.R.C.P.Lond., L.S.A., of Henley-on-Thames.



# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXIII.

WEDNESDAY, JULY 31, 1901.

No. 5.

## Original Communications.

THE

### COMBATING OF TUBERCULOSIS IN THE LIGHT OF THE EXPERI- ENCE THAT HAS BEEN GAINED IN THE SUCCESSFUL COMBATING OF OTHER INFECTIOUS DISEASES. (a)

By Geh. Med.-Rath Professor Dr. ROBERT KOCH,  
Direktor des Instituts für Infektionskrankheiten in Berlin.

We understand by tuberculosis only those morbid conditions which are caused by the tubercle bacillus. In by far the majority of cases of tuberculosis the disease has its seat in the lungs, and has also begun there. From this fact it is justly concluded that the germs of the disease, *i.e.*, the tubercle-bacilli, must have got into the lungs by inhalation. As to the question where the inhaled tubercle-bacilli come from there is also no doubt. On the contrary, we know with certainty that they get into the air with the sputum of consumptive patients. This sputum, especially in advanced stages of the disease, almost always contains tubercle bacilli, sometimes in incredible quantities. By coughing, and even speaking, it is flung into the air in little drops, *i.e.*, in a moist condition, and can at once infect persons who happen to be near the coughers. But then it may also be pulverised when dried, in the linen or on the floor for instance, and get into the air in the form of dust.

In this manner a complete circle, a so-called *circulus vitiosus*, has been formed for the process of infection, from the diseased lung, which produces phlegm and pus containing tubercle-bacilli, to the formation of moist and dry particles (which, in virtue of their smallness, can keep floating a good while in the air), and finally to new infection, if particles penetrate with the air into a healthy lung and originate the disease anew. But the tubercle-bacilli may get to other organs of the body in the same way, and thus originate other forms of tuberculosis. This, however, is a considerably rarer case. The sputum of consumptive people, then, is to be regarded as the main source of the infection of tuberculosis. On this point, I suppose, all are agreed. The question now arises whether there are not other sources too, copious enough to demand consideration in the combating of tuberculosis.

Great importance used to be attached to the hereditary transmission of tuberculosis. Now, however, it has been demonstrated by thorough investigation that, though hereditary tuberculosis is not absolutely non-existent, it is nevertheless extremely rare, and we are at liberty, in considering our prac-

tical measures, to leave this form of origination entirely out of account.

But another possibility of tuberculous infection exists, as is generally assumed, in the transmission of the germs of the disease from tuberculous animals to man. This manner of infection is generally regarded nowadays as proved, and as so frequent that it is even looked upon by not a few as the most important, and the most rigorous measures are demanded against it. In this Congress also the discussion of the danger with which the tuberculosis of animals threatens man will play an important part. Now, as my investigations have led me to form an opinion deviating from that which is generally accepted, I beg your permission, in consideration of the great importance of this question, to discuss it a little more thoroughly.

Genuine tuberculosis has hitherto been observed in almost all domestic animals, and most frequently in poultry and cattle. The tuberculosis of poultry, however, differs so much from human tuberculosis that we may leave it out of account as a possible source of infection for man. So, strictly speaking, the only kind of animal tuberculosis remaining to be considered is the tuberculosis of cattle, which, if really transferable to man, would indeed have frequent opportunities of infecting human beings through the drinking of the milk and the eating of the flesh of diseased animals.

Even in my first circumstantial publication on the etiology of tuberculosis I expressed myself regarding the identity of human tuberculosis and bovine tuberculosis with reserve. Proved facts which would have enabled me sharply to distinguish these two forms of the disease were not then at my disposal, but sure proof of their absolute identity were equally undiscoverable, and I therefore had to leave this question undecided. In order to decide it, I have repeatedly resumed the investigations relating to it, but so long as I experimented on small animals, such as rabbits and guinea pigs, I failed to arrive at any satisfactory result, though indications which rendered the difference of the two forms of tuberculosis probable were not wanting. Not till the complaisance of the Ministry of Agriculture enabled me to experiment on cattle, the only animals really suitable for these investigations, did I arrive at absolutely conclusive results. Of the experiments which I have carried out during the last two years along with Professor Shütz, of the Veterinary College in Berlin, I will tell you briefly some of the most important.

A number of young cattle which had stood the tuberculin test, and might therefore be regarded as free from tuberculosis, were infected in various ways with pure cultures of tubercle-bacilli taken from cases of human tuberculosis; some of them got the tuberculous sputum of consumptive patients direct. In some cases the tubercle-bacilli or the sputum were injected under the skin, in others into the peritoneal cavity, in others into the jugular vein.

(a) Abstract of Address read before the British Congress on Tuberculosis, London, July, 1901.

Six animals were fed with tuberculous sputum almost daily for seven or eight months; four repeatedly inhaled great quantities of bacilli, which were distributed in water and scattered with it in the form of spray. None of these cattle (there were nineteen of them) showed any symptoms of disease, and they gained considerably in weight. From six to eight months after the beginning of the experiments they were killed. In their internal organs not a trace of tuberculosis was found. Only at the places where the injections had been made small suppurative foci had formed, in which few tubercle-bacilli could be found. This is exactly what one finds when one injects dead tubercle-bacilli under the skin of animals liable to contagion. So the animals we experimented on were affected by the living bacilli of human tuberculosis exactly as they would have been by dead ones; they were absolutely insusceptible to them.

The result was utterly different, however, when the same experiment was made on cattle free from tuberculosis with tubercle-bacilli that came from the lungs of an animal suffering from bovine tuberculosis. After an incubation-period of about a week the severest tuberculous disorders of the internal organs broke out in all the infected animals. It was all one whether the infecting matter had been injected only under the skin or into the peritoneal cavity or the vascular system. High fever set in, and the animals became weak and lean; some of them died after a month and a half to two months, others were killed in a miserably sick condition after three months. After death extensive tuberculous infiltrations were found at the place where the injections had been made, and in the neighbouring lymphatic glands, and also far advanced alterations of the internal organs, especially the lungs and the spleen. In the case in which the injection had been made into the peritoneal cavity the tuberculous growths which are so characteristic of bovine tuberculosis were found on the omentum and peritoneum. In short, the cattle proved just as susceptible to infection by the bacillus of bovine tuberculosis as they had proved insusceptible to infection by the bacillus of human tuberculosis. I wish only to add that preparations of the organs of the cattle which were artificially infected with bovine tuberculosis in these experiments are exhibited in the Museum of Pathology and Bacteriology.

An almost equally striking distinction between human and bovine tuberculosis was brought to light by a feeding experiment with swine. Six young swine were fed daily for three months with the tuberculous sputum of consumptive patients. Six other swine received bacilli of bovine tuberculosis with their food daily for the same period. The animals that were fed with sputum remained healthy and grew lustily, whereas those that were fed with the bacilli of bovine tuberculosis soon became sickly, were stunted in their growth, and half of them died. After three months and a half the surviving swine were all killed and examined. Among the animals that had been fed with sputum no trace of tuberculosis was found, except here and there little nodules in the lymphatic glands of the neck, and in one case a few grey nodules in the lungs. The animals, on the other hand, which had eaten bacilli of bovine tuberculosis had, without exception (just as in the cattle experiment), severe tuberculous diseases, especially tuberculous infiltration of the greatly enlarged lymphatic glands of the neck and of the mesenteric glands, and also extensive tuberculosis of the lungs and the spleen.

The difference between human and bovine tuberculosis appeared not less strikingly in a similar experiment with asses, sheep, and goats, into whose vascular systems the two kinds of tubercle-bacilli were injected.

Our experiments, I must add, are the only ones that have led to this result. If one studies the older literature of the subject, and collates the reports of the numerous experiments that were made in former times by Chauveau, Günther and Harms, Bollinger, and others, who fed calves, swine, and goats with tuberculous material, one finds that the animals that were fed with the milk and pieces of the lungs of tuberculous cattle always fell ill of tuberculosis, whereas those that received human material with their food did not. Comparative investigations regarding human and bovine tuberculosis have been made very recently in North America by Smith, Dinwiddie and Frothingham, and their result agreed with that of ours. The unambiguous and absolutely conclusive result of our experiments is due to the fact that we chose methods of infection which exclude all sources of error, and carefully avoided everything connected with the stalling, feeding, and tending of the animals that might have a disturbing effect on the experiments.

Considering all these facts, I feel justified in maintaining that human tuberculosis differs from bovine, and cannot be transmitted to cattle. It seems to me very desirable, however, that these experiments should be repeated elsewhere in order that all doubt as to the correctness of my assertion may be removed.

But now, how is it with the susceptibility of man to bovine tuberculosis? This question is far more important to us than that of the susceptibility of cattle to human tuberculosis, highly important as that is too. It is impossible to give this question a direct answer, because, of course, the experimental investigation of it with human beings is out of the question. Indirectly, however, we can try to approach it. It is well known that the milk and butter consumed in great cities very often contain large quantities of the bacilli of bovine tuberculosis in a living condition, as the numerous infection-experiments with such dairy products on animals have proved. Most of the inhabitants of such cities daily consume such living and perfectly virulent bacilli of bovine tuberculosis, and unintentionally carry out the experiment which we are not at liberty to make. If the bacilli of bovine tuberculosis were able to infect human beings, many cases of tuberculosis caused by the consumption of aliments containing tubercle-bacilli could not but occur among the inhabitants of great cities, especially the children. And most medical men believe that this is actually the case.

In reality, however, it is not so. That a case of tuberculosis has been caused by aliments can be assumed with certainty only when the intestine suffers first—i.e., when a so-called primary tuberculosis of the intestine is found. But such cases are extremely rare. Among many cases of tuberculosis examined after death, I myself remember having seen primary tuberculosis of the intestine only twice. Among the great post-mortem material of the Charité Hospital in Berlin ten cases of primary tuberculosis of the intestine occurred in five years. Among 933 cases of tuberculosis in children at the Emperor and Empress Frederick's Hospital for Children, Baginsky never found tuberculosis of the intestine without simultaneous disease of the lungs and the bronchial glands. Among 3,104 post-mortems of tuberculous children, Biedert observed only sixteen cases of primary tuberculosis of the intestine. I could cite from the literature of the subject many more statistics of the same kind, all indubitably showing that primary tuberculosis of the intestine, especially among children, is a comparatively rare disease, and of these few cases that have been enumerated, it is by no means certain that they were due to infection by bovine tuberculosis. It is just as likely that they were caused by the widely propagated bacilli of human tuberculosis, which may

have got into the digestive canal in some way or other—for instance, by swallowing saliva of the mouth. Hitherto nobody could decide with certainty in such a case whether the tuberculosis of the intestine was of human or of animal origin. Now we can diagnose them. All that is necessary is to cultivate in pure culture the tubercle-bacilli found in the tuberculous material, and to ascertain whether they belong to bovine tuberculosis by inoculating cattle with them. For this purpose I recommend subcutaneous injection, which yields quite specially characteristic and convincing results. For half a year past I have occupied myself with such investigations, but, owing to the rareness of the disease in question, the number of the cases I have been able to investigate is but small. What has hitherto resulted from this investigation does not speak for the assumption that bovine tuberculosis occurs in man.

Though the important question whether man is susceptible to bovine tuberculosis at all is not yet absolutely decided, and will not admit of absolute decision to-day or to-morrow, one is nevertheless already at liberty to say that, if such a susceptibility really exists, the infection of human beings is but a very rare occurrence. I should estimate the extent of infection by the milk and flesh of tuberculous cattle, and the butter made of their milk, as hardly greater than that of hereditary transmission, and I therefore do not deem it advisable to take any measures against it.

So the only main source of the infection of tuberculosis is the sputum of consumptive patients, and the measures for the combating of tuberculosis must aim at the prevention of the dangers arising from its diffusion. Well, what is to be done in this direction? Several ways are open. One's first thought might be to consign all persons suffering from tuberculosis of the lungs, whose sputum contains tubercle-bacilli to suitable establishments. This, however, is not only absolutely impracticable, but also unnecessary. For a consumptive who coughs out tubercle-bacilli is not necessarily a source of infection on that account, so long as he takes care that his sputum is properly removed and rendered innocuous. This is certainly true of very many patients, especially in the first stages, and also of those who belong to the well-to-do classes, and are able to procure the necessary nursing. But how is it with people of very small means? Every medical man who has often entered the dwellings of the poor, and I can speak on this point from my own experience, knows how sad is the lot of consumptives and their families there. The whole family have to live in one or two small, ill-ventilated rooms. The patient is left without the nursing he needs, because the able-bodied members of the family must go to their work. How can the necessary cleanliness be secured under such circumstances? How is such a helpless patient to remove his sputum, so that it may do no harm? But let us go a step further and picture the condition of a consumptive patient's dwelling at night. The whole family sleep crowded together in one small room. However cautious he may be, the sufferer scatters the morbid matter secreted by his diseased lungs every time he coughs, and his relatives close beside him must inhale this poison. Thus whole families are infected. They die out, and awaken in the minds of those who do not know the infectiousness of tuberculosis the opinion that it is hereditary, whereas its transmission in the cases in question was due solely to the simplest processes of infection, which do not strike people so much, because the consequences do not appear at once, but generally only after the lapse of years. Often, under such circumstances, the infection is not restricted to a single family, but spreads in densely inhabited tenement-

houses to the neighbours, and then, as the admirable investigations of Biggs have shown in the case of the densely peopled parts of New York, regular nests or foci of disease are formed.

If we are not able at present to get rid of the danger which small and overcrowded dwellings involve, all we can do is to remove the patients from them, and, in their own interests and that of the people about them, to lodge them better; and this can be done only in suitable hospitals. But the thought of attaining this end by compulsion of any kind is very far from me; what I want is that the consumptives may be enabled to obtain the nursing they need better than they can obtain it now. At present a consumptive in an advanced stage of the disease is regarded as incurable and as an unsuitable inmate for a hospital. The consequence is that he is reluctantly admitted and dismissed as soon as possible. The patient too, when the treatment seems to him to produce no improvement, and the expenses, owing to the long duration of his illness, weigh heavily upon him, is himself animated by the wish to leave the hospital soon. That would be altogether altered if we had special hospitals for consumptives, and if the patients were taken care of there for nothing, or at least at a very moderate rate. To such hospitals they would willingly go; they could be better treated and cared for there than is now the case. As however, unfortunately, the aid of the state, the municipalities, and rich benefactors will probably not be forthcoming for a long time yet, we must for the present resort to other measures that may pave the way for the main measures just referred to, and serve as a supplement and temporary substitute for it.

Among such measures I regard obligatory notification as specially valuable. In the combating of all infectious diseases it has proved indispensable as a means of obtaining certain knowledge as to their state, especially their dissemination, their increase and decrease. In the conflict with tuberculosis also we cannot dispense with obligatory notification; we need it not only in order to inform ourselves as to the dissemination of this disease, but mainly in order to learn where help and instruction can be given, and especially where the disinfection which is so urgently necessary when consumptives die or change their residences has to be effected. Fortunately it is not at all necessary to notify all cases of tuberculosis, nor even all cases of consumption, but only those that, owing to the domestic conditions, are sources of danger to the people about them.

There is another measure, closely connected with notification, viz., disinfection, which, as already mentioned, must be effected when consumptives die or change their residence, in order that those who next occupy the infected dwelling may be protected against infection. Moreover, not only the dwellings but also the infected beds and clothes of consumptives ought to be disinfected. A further measure, already recognised on all hands as effective, is the instructing of all classes of the people as to the infectiousness of tuberculosis, and as to the best way of protecting oneself. The fact that tuberculosis has considerably diminished in almost all civilised states of life is attributable solely to the circumstance that knowledge of the contagious character of tuberculosis has been more and more widely disseminated, and that caution in intercourse with consumptives has increased more and more in consequence. Another measure, which has come into the foreground of late, and which at this moment plays to a certain extent a paramount part in all efforts for the combating of tuberculosis, works in quite another direction. I mean the founding of sanatoria for consumptives.

That tuberculosis is curable in its early stages

must be regarded as an undisputed fact. The idea of curing as many tuberculous patients as possible in order to reduce the number of those that reach the infectious stage of consumption, and thus to reduce the number of fresh cases, was therefore a very natural one. The only question is whether the number of persons cured in this way will be great enough to exercise an appreciable influence on the retrogression of tuberculosis. I will try to answer this question in the light of the figures at my disposal.

If now, in conclusion, we glance back once more to what has been done hitherto for the combating of tuberculosis, and forward to what has still to be done, we are at liberty to declare with a certain satisfaction that very promising beginnings have already been made. Among these I reckon the consumption hospitals of England, the legal regulations regarding notification in Norway and Saxony, the organisation created by Biggs in New York, the sanatoria, and the instruction of the people. All that is necessary is to go on developing these beginnings, to test, and if possible to increase their influence on the diminution of tuberculosis, and wherever nothing has yet been done, to do likewise.

If we are continually guided in this enterprise by the spirit of genuine preventive medical science, if we utilise the experience gained in conflict with other pestilences, and aim, with clear recognition of the purpose and resolute avoidance of wrong roads, at striking the evil at its root, then the battle against tuberculosis, which has been so energetically begun, cannot fail to have a victorious issue.

## MEASURES FOR THE PREVENTION OF CONSUMPTION. (a)

By Professor BROUARDEL,

Dean of the Faculty of Medicine of Paris, Member of the Institute.

THE mortality from tuberculosis varies according to the country. In some cases it is accountable for a sixth, a fifth, and sometimes a fourth of the total mortality. Havoc such as this makes it compulsory that all nations and governments should strictly inquire into, and adopt, measures to arrest the propagation of a disease which, in these days, is the greatest enemy of the human race. The wonder is that the voice of alarm has been so long in making itself heard, and that for centuries our ancestors have looked impassively on the disasters going on around them. There were several reasons for this apparent indifference. The struggle was considered useless; the disease incurable; it was not known how it spread. Exaggerating the import of some observations, it was agreed that phthisis is hereditary. They were lulled to sleep by this formula, which served as a pillow for idleness and exempted them from investigating the origin of the mischief.

But when, on December 5th, 1865, Villemin showed experiments at the Academy of Medicine, which proved the real presence of the contagion, when our illustrious colleague, Professor Robert Koch, had discovered and demonstrated to the medical world the agent of this contagion, everyone felt that a new way was opened to humanity, and every nation wished to profit for the public good, by the recent scientific discoveries. Before the scientists I have just mentioned had actually made known their discoveries, the English people had already begun the struggle. Convinced by observation that tuberculosis thrived in dark and damp dwellings, in 1836—nearly seventy years ago—you passed a law providing for the construction of healthy houses, and since that date your

zeal has not abated. The grounds for the prevention of tuberculosis are identical in every country. On this question the entire medical profession of the world is united. Tuberculosis is avoidable and curable. With regard to legislation, it is only possible to bring a law into force that interferes with our daily life, that disturbs inveterate habits, and that has to be carried out in the bosom of the domestic hearth, when it is called for by public opinion: when all are convinced of its benefits, and everyone recognises the danger of his vicious habits, and is ready personally to reform them and to require his neighbour to do the same.

Gradually in all countries the public are beginning to realise that personal care and cleanliness are necessary to obviate contagion, and are also realising that other idea, to my mind equally important, that a consumptive patient is only dangerous if the necessary precautions are not taken around him, and if he himself does not take them to protect his relatives, friends, and fellow-workmen from contagion. The danger is in the sputum, which contains thousands of contagious germs. To expectorate on the ground is a disgusting and dangerous habit. Once this habit has quite disappeared, tuberculosis will decrease rapidly.

What rôle does this sputum play in the subsequent propagation of the disease? Collected and shut up in a private, or common but antiseptic, spittoon, destroyed by incineration or some other measure, it is dangerous to no one. Thrown into dry and well-lighted surroundings, exposed to the rays of the sun, it will soon lose its dangerous properties. But if it remains in damp and dark surroundings, it will maintain its activity for a long time. Thus it is that tuberculosis claims more victims from gloomy, ill-ventilated, dark dwellings. All nations have recognised this, but England has the double merit of recognising the primary importance of this problem, and of having solved it in a manner peculiarly her own. Recognising that insalubrious dwellings are one of the most potent agents in propagation of tuberculosis, the legislations of the different countries have kept this cause of insalubrity well in view, and have made laws ordering the destruction of unhealthy dwellings.

If tuberculous germs fall in an ill-lighted, damp house they maintain their activity for a long time, whether the house is in town or country. In these surroundings population is often very dense. It is no uncommon thing to see one room in Paris occupied by five, six, eight, and sometimes twelve persons. They are continually coming in contact with one another, chances of contagion are increased by this fact alone, and in addition to the limited space has to be added the dirtiness of the occupants, or, as I should say, the impossibility of keeping sufficiently clean. The small tuberculous foci are created which invade the whole house; the workmen and employés carry the germs of disease into their workshops and offices and soon make a large tuberculous focus of the town.

The evils of an unhealthy dwelling are not confined to the risk of contagion just referred to. The want of air and light acts on the nutrition of the inmates, children go off, pine away, the strongest men cannot withstand it, every human being living in these places is the destined prey of infectious diseases; and if we only consider phthisis they become predisposing causes of consumption, transforming the strongest man and putting him on a par with the condition of those born of tuberculous parents. In the latter, heredity is not direct; one is not born tuberculous, but predisposed to tuberculosis. Moreover, unhealthy dwellings are not pleasant to pass the time in, and the workman stays

(a) Address to the British Congress on Tuberculosis, July, 1901.

in his home as little as possible, spending the rest of his time in the public-house, and we can add that the public-house is the purveyor of tuberculosis. Alcoholism is, in fact, the most potent factor in propagating tuberculosis. The strongest man, who has once taken to drink, is powerless against it.

Any measures, State or individual, tending to limit the ravages of alcoholism will be our most precious auxiliaries in the crusade against tuberculosis, but the question is too large a one to deal with here.

The dangers surrounding a man in an unhealthy home are the same when for his work, his duties, his pleasure, through illness, or under constraint, he lives all or part of the day in a centre where other people are assembled, where unhealthy conditions and overcrowding exist. If he is well, his companions are dangerous to him; if he is ill, he is dangerous to them. Now the conditions of modern life compel a man to live in such centres. As a child there is the school; as an adult, the barracks; a workman, the workshop; a student, the lecture hall, the libraries, laboratories; the employé or official, the bureau and the offices. If he moves about he uses vehicles, railway carriages, too often contaminated.

At the hotel where he stops he has frequently been preceded by a sick person, and no precautions have been taken to protect the new arrival from possible contagion. If he is poor and ill he goes into a hospital, where he is surrounded by contamination on every hand. This peril from common life, inseparable from advance in civilisation, is continually growing: it is the ransom, and accounts for the threatening increase in tuberculosis.

Before touching on the question of the cure of tuberculosis I should like to say a few words about measures adopted to prevent tuberculous contagion by food. Since Chauveau showed that it was possible for tuberculous germs in food to produce tubercles in the intestinal tract, attention has been turned to precautions for preventing the consumption of meat and milk from tuberculous animals. As far as meat is concerned, surveillance of the slaughter-houses in large towns achieves this. In Belgium this measure is also made to apply to the country; but I do not know of any other kingdom where private slaughter-houses are inspected, and in them it is that phthisical cows, mealy pigs, and diseased animals of any kind are slaughtered, and are able to escape inspection. This injurious food is consumed either as fresh meat, or in the form of pâtés or sausages from which the tuberculous viscera have not been removed. Another danger is the hawking of meat in pieces. It is rife especially in the large towns. Butchers receive daily quarters of meat despatched by provincial butchers. This meat escapes inspection. With no wish to exaggerate the danger of the propagation of tuberculosis by meat, it cannot be overlooked. It is easy, by means of legislation, to protect the population from this method of contamination. Belgium has set us the example. That the milk of cows with tuberculous inflammation of udders is used is very clear.

It is well to add that in large concerns the milk from different sources is mixed, and one cow only need be the victim of tuberculous mammitis in order to contaminate all the milk with which its milk is mixed. To prevent this method of propagation, strict inspection measures should be adopted, such as have been in use for several years in Denmark, Sweden, and Norway, to the great advantage of public health. Until such necessary measures are actually adopted there only remains the simple mode of avoiding risk from milk by boiling it, and this should be widely made known, in spite of a too widespread prejudice, which wrongly holds that boiled milk is less nutritious and indigestible. If a man is

the victim of tuberculosis everything possible should be done to cure him, for *he can be cured*. The idea that tuberculosis can be cured dates back to Hippocrates: "Phthisis, if treated early enough, gets well," said the Father of Medicine.

At the Morgue, in Paris, where I frequently make post-mortems on accidental deaths, I can state that in half the cases, if the person on whom the post-mortem is made has lived in Paris for about ten years, I find healed tuberculous lesions, either in the form of cretaceous transformation or fibrous cicatrization. These lesions, moreover, in the majority of cases, are not phthisis in an early stage manifested by small disseminated foci; they are cicatrices of large foci, sometimes of wide completely cicatrised cavities. Phthisis therefore is curable, even in its most advanced stages. As a tuberculous patient can be cured, everything possible must be done to bring this about by careful organisation. The doctor being himself firmly convinced that his patient can be cured will make the necessary modifications in his way of looking at the disease.

The doctor shall tell the patient and his family at once that he has a serious disease, but that it is curable.

And now as to the methods of treatment. In this address I am only dealing with the disease as it affects working men and employés.

The remedies to be recommended vary according to the stage to which the disease has got, and also if the patient is single, married, or father of a family.

Three distinct periods may be defined. In the earliest the patient coughs and has a cold, and it is this stage of the disease which interests us most, when intervention is of use.

In what way can we be of use to a patient in the first stage? In Germany there are polyclinics for tuberculosis in the large towns, where a doctor, provided with the things necessary, attends to the patients who come to consult him, either throughout their illness, or till the patient can be admitted into a sanatorium. A committee, composed of benevolent men, and women in large numbers, looks after the patient at home, tells his wife what to do, sees that his home is kept clean, and looks after necessary prophylactic measures. As far as possible, the misery consequent on the breadwinner being out of work is relieved from a bank, kept up like the sanatoria banks to assist such cases. Mons. Calmette conceived the same idea, but he went farther, and advised that, instead of waiting for the workman to come for advice, they should go and meet him by inviting him to come to a dispensary, run on the same lines as the German polyclinics.

As far as I can see, the best way to ferret out disease would be to have one or more agent-workmen, foremen-workmen, if it were possible. They are the ones to notice when their comrades cough; they could advise them to go to the dispensary. Alive to the dangers of a badly-kept workshop or yard, they superintend its being kept clean and in order; they actually carry out anti-tuberculous education. Those who visit the dispensary receive the necessary attention from the doctors, and are told the danger of dissemination by sputum, alcoholism, &c. They are looked after, they get meat gravy—one or two meals, as far as funds will allow. Their families are helped and their home is kept an eye on from the hygienic point of view; as far as possible, the misery by which the poor man is threatened is kept away from him. Among these patients some are found who must be sent to a sanatorium. If the patient is an unmarried man, and if he can be sent to a sanatorium, his chances of recovery are very great; but for a married man to go means that his wife and family must be provided for

during his absence, and his mind relieved of all anxiety on their account.

Relief banks for assisting the families of the inmates are most necessary to sanatoria. And in many cases sanatoria are essential to complete the work begun at the dispensary.

All nations have obeyed the same generous impulses, and the time will come when, instead of the poor tuberculous patient being given up to his sad lot, he will find that if he is only in the first stages of the disease, that by means of dispensaries and sanatoria there is always hope and often realisation of his recovery. If the patient is beyond the first two stages when he asks for admission to the hospital, it must not be overlooked that he may still be cured, provided he can be made to see things as they are. He may be isolated, in order that he may not be discouraged by the spectacle of his comrades' sufferings.

I have been asked to consider the question from the international point of view. I do not think that it is possible to deal with consumption in this respect as plague, cholera, and yellow fever have been dealt with in order to prevent their being brought into a country. I do not know how any doctor can state positively that a traveller at the frontier or the port is not consumptive. But it would be possible to take international steps in another way. Railway carriages might be disinfected, as well as steamboats and hotels, and the traveller no longer exposed to germs of contagion. That would be of truly international import. In several countries, particularly in the United States, hotel keepers who receive a consumptive client have to notify it to the municipal authorities, and compulsory disinfection of the room has to be gone through. The Minister of the Interior in Germany has brought in even more stringent measures. Every doctor who attends a case of pulmonary or laryngeal tuberculosis is bound to report it in writing to the police as soon as he has made his diagnosis. After death from tuberculosis the room in which the patient has died has to be disinfected as well as his belongings. Hotel proprietors, "furnished house" keepers, asylums, and other public institutions are compelled to notify at once every case of tuberculous disease which arises in their establishments. Notification, disinfection, salubrity of hotels, carriages, and steamboats, are questions of an international character, which might be advantageously dealt with by representatives of the different nations.

The lesson to be drawn from the efforts that have been made by all nations to carry out a crusade against tuberculosis is that in conversation, in the public prints, and in specially prepared pamphlets, we should make it universally known that tuberculous contamination can be avoided, and that in addition the disease can be cured.

## HUMAN AND BOVINE TUBERCULOSIS. (a)

By Professor MCFADYEAN,  
Of the Royal Veterinary College, &c.

AFTER some preliminary remarks in regard to the supposed identity of the organism of tuberculosis in man and animals, the Professor observed that the view that bovine and human tuberculosis are identical diseases was generally supposed to have been finally determined by Dr. Koch himself, when he discovered that the human and the bovine lesions contained bacilli that were identical in morphological, tinctorial, and cultural characters, and showed

that the artificial cultures from both sources produced indistinguishable effects when they were employed to infect a variety of animals. He pointed out that tuberculin produced a specific reaction in tuberculous cattle, whether human or bovine bacilli had been employed in its preparation. In short, the identity of the bacilli from the two sources appeared to be as firmly established as any other generally accepted opinion regarding the identity or non-identity of bacteria associated with disease in more than one species of animal. Opinions varied as to the frequency with which this transmission of tuberculosis from one species to the other occurred, but practically never within the last eighteen years regarding the possibility and probability of reciprocal infection. What then were the grounds upon which they were asked to discard convictions that appeared to rest on such a solid basis? He would endeavour to state them briefly, as he understood Dr. Koch's train of reasoning:—(1) The bacilli found in cases of bovine tuberculosis are much more virulent for cattle and other domesticated quadrupeds than the bacilli found in cases of human tuberculosis. (2) This difference is so marked and so constant that it may be relied upon as a means of distinguishing the bacilli of bovine tuberculosis from those of the human disease, even assuming that the former may occasionally be found as a cause of disease in man. (3) If bovine bacilli are capable of causing disease in man, there are abundant opportunities for the transference of the bacilli from the one species to the other, and cases of primary intestinal tuberculosis from the consumption of tuberculous milk ought to be of common occurrence. But post-mortem examination of human beings proves that cases of primary intestinal tuberculosis are extremely rare in man, and therefore it must be concluded that the human subject is immune against infection with the bovine bacilli, or is so slightly susceptible that it is not necessary to take any steps to counteract the risk of infection in this way.

He admitted that what may be called bovine tubercle-bacilli are as a rule distinctly more virulent for cattle and other domesticated animals than human bacilli, or that the results of experiments indicate that in natural circumstances there is little danger of cattle becoming infected from human beings. But it could not be admitted that the low virulence of human bacilli for cattle proves, or even makes it probable, that bovine bacilli have only a feeble pathogenic power for man. That might have been held to be probable if it had been shown that bovine bacilli were very virulent only for cattle; but since it is well established that these bacilli are highly dangerous for such diverse species as the rabbit, horse, dog, pig, and sheep, and, in short, for almost every quadruped on which they have been tried, it appeared to be highly probable that they are also dangerous to man. At any rate, it was impossible to cite any ascertained fact relating to other bacterial diseases that made the contrary conclusion probable. It was well known that the majority of disease-exciting bacteria are harmful to only one or two species, but all those that are common to all the domesticated animals are also pathogenic to man. With regard to the view that the difference between human and bovine bacilli in respect of virulence for cattle is of such a fixed and constant character that it may be relied upon to distinguish the one from the other, it need only be said that that was very far from proved. It appeared to be quite possible that what might be called the normal or average virulence of bovine bacilli for cattle might be reduced by passage through the human subject. Besides, there were very great differences in the virulence of tubercle-bacilli found in animals of the same species, and if a low degree for virulence for cattle were to be

(a) Abstract of Address delivered before the British Congress on Tuberculosis, July, 1901.

taken as the distinguishing feature of human bacilli, there would be no difficulty in proving that the human disease is sometimes transmitted to the lower animals.

The third proposition in Dr. Koch's argument was the only one which was really germane to the point at issue, viz., that only cases of primary intestinal tuberculosis can possibly have had their origin in infected milk or meat, and that "such cases are extremely rare." Dr. Koch referred to several series of post-mortem observations that appeared to justify this statement, and added that he could have cited many more pointing to the same conclusion. He pointed out that statistics were not by any means unanimous, and those that were likely to appeal with most force to the people in this country were not at all in accord with those quoted from Germany. During the last few years the evidence obtainable from the post-mortem records of two of the largest hospitals for children in this country had been analysed with great care, in order to see what evidence they afforded as to the relative frequency of the different methods of infection in tuberculosis. In the case of the Hospital for Sick Children in Great Ormond Street this had been done by Dr. George Still, and in the case of the Royal Hospital for Sick Children in Edinburgh by Dr. Shennan. The conclusion at which Dr. Still arrived was that in 29.1 per cent. of the cases of tuberculosis in children primary infection appeared to have taken place through the intestine. That was very far from being an insignificant proportion, and it was a striking fact that Dr. Shennan arrived at an almost identical conclusion, and estimated that 28.1 per cent. of the cases of tuberculosis among children in Edinburgh are due to alimentary affection. In face of these statistics it was not possible to assent to the statement that cases of primary tuberculosis of the alimentary canal are extremely rare. Precisely the contrary conclusion was the one that must in the meanwhile be drawn with regard to the state of affairs in this country, viz., that, at least in children, primary infection by way of the alimentary canal is comparatively common. In respect of the proportion of these cases which ought to be ascribed to tubercle-infected milk, he recalled the fact that the late Sir Richard Thorne Thorne, in the Harben Lectures on the administrative control of tuberculosis, which he delivered in 1898, expressed his conviction that tuberculous milk was the main cause of *tabes mesenterica* in children, and he characterised the loss of child life from this cause as appalling. On the strength of the Registrar-General's returns, which showed that during the last fifty years there had been a marked decline in the death-rate from human phthisis, which is the form that tuberculosis generally takes when the bacilli are inhaled. On the other hand, during the same period there had been only a slight decline in the death-rate at all ages from that form of tuberculosis which is ascribable to alimentary infection, and among children under one year of age there had been a notable increase in the mortality from that form of the disease, which he attributed to infection through milk, which had remained unchecked. He was, however, prepared to admit that there were several weak points in this argument.

He pointed out that about 30 per cent. of all the cows giving milk in this country were tuberculous in some degree, and about 2 per cent. of the cows had tuberculous udders. Now, the milk secreted by a tuberculous udder always contained tubercle-bacilli, and it sometimes contained enormous numbers of them, and when these facts were apprehended one began to realise the seriousness of the danger to which, in the present state of affairs, those who drink uncooked milk are exposed.

The Professor concluded his remarks by urging the necessity for educating the public in the nature of the disease, and of instituting a system of inspection of cows. He insisted on the fact that the inhalation of tubercle-bacilli expelled from the bodies of human patients was doubtless the great cause of human tuberculosis, and every practicable means of preventing infection in that way ought to be employed; but, at the same time, they ought not to concede to the milkmen the right to sell us tubercle-bacilli, even if we were assured that—like Dr. Koch's experimental pigs—we had nothing to fear beyond the development of "little nodules here and there in the lymphatic glands" of our necks and "a few grey tubercles" in our lungs.

## REMARKS ON THE DEGENERATIONS AND COMPLICATIONS

OF

### UTERINE MYOMATA. (a)

By H. MACNAUGHTON-JONES, M.D.,  
M.A.O., M.Ch., &c.

It is unnecessary for me to remark that the importance of a subject connected with the degenerations and associated complications of uterine myoma can hardly be exaggerated; it is the turning point upon which future practice will in great measure depend. I have gone to the trouble of having the museums of some of the largest London hospitals searched with reference to the subject, and also the museum of the Royal College of Surgeons. The point I wish to make is that gynecologists are really beginning a new era in connection with that disease. The great majority of specimens shown at various societies are presented as proofs of the operator's skill and dexterity, and no doubt are interesting from their size and from the point of view of technique, as illustrating the difficulty of removal. Numbers of these tumours have been looked at and not even opened, and without any report having accompanied them as to the pathological nature of the growth removed. Countless numbers of valuable specimens must have been destroyed as useless which would have materially altered the view which has been taken with regard to the treatment of myoma if these had been preserved and reported upon.

In the Museum of the Royal College of Surgeons of England there are in all 47 specimens marked definitely as fibrous tumours of the uterus. Of these, 33 are described as having undergone ulceration, degeneration, or been complicated by adhesions, pregnancy, or ovarian tumours. These we may divide as follows:—Pressure of ureters, 1; ulceration of the tumour, 3; ulceration of the vagina, 1; calcification, 3; cystic degeneration, 1; with complications of the adnexa, 6; with pregnancy, 5.

In St. Bartholomew's Hospital Museum there are examples of the following degenerations and complications:—Cystic degeneration, 3; calcification, 2; myoma complicated with diseases of the adnexa, 5; myoma with cancer, 1; degenerating myoma with cavity containing serous fluid, 1.

In University College Hospital Museum there are the following:—Sloughing myoma, 1; fungoid degeneration with ulceration, 1; suppurating myoma with calcareous degeneration, 1; calcareous degeneration with adnexal complications, 2; calcareous degeneration alone, 5.

In the Westminster Hospital Museum there is 1 specimen of calcareous degeneration. In St. George's

(a) Remarks made in opening the Discussion on Dr. Charles Noble's paper at the British Gynecological Society, on July 11th, 1901.

Hospital Museum there are 4 specimens of calcareous degeneration of myoma, 2 of myoma complicated with pregnancy, 1 of myxomatous degeneration, and 1 of fibro-cystic degeneration.

In King's College Hospital Museum there were none. Mr. Cheate has kindly lent me one of carcinoma and myoma.

In St. Mary's Hospital Museum are the 6 specimens exhibited here to-night.

Those from the Cancer Hospital were also before the Society, 10 in number (Mr. Jessett's).

I think that the inference is clear from the enormous number of cases which must have passed through these hospitals, that a huge mass of material has been unobserved or unrecorded.

In future I trust that specimens which are presented of myoma or of complicated myoma will be accompanied by a proper pathological report, not only setting forth the inherent characteristics of the tumour itself, but the adnexal or other complications that have been associated with it. Then gynecologists will have something definite to rely upon.

Dr. Charles Noble, in his paper, has referred to the menopause. I take it that no one now advances the argument that the danger of a myoma is lessened by the menopause. On the table is a tumour which I exhibited at the Society, removed from a woman who had been suffering from profound anæmia, so bad that it was with great apprehension I thought of operating upon her. The woman was restored to perfect health. There had been mucoid degeneration, and the tumour, a multiple myoma, weighed eight pounds. A very important point about the menopause is the following. We speak of climacteric insanity; and if there be one point settled among psychologists more than another it is the fact that myoma has very frequently a distinct effect on the mentalisation of the woman. Of that I have no doubt whatever. I have seen two or three instances of actual dementia, and one of mania complicating myoma at the menopause. There is thus a distinct danger at this time, a point not dwelt upon by Dr. Charles Noble as fully as it might have been. One must consider carefully the mental effects of the tumour on a woman, not only from the constant introspection induced by the presence of the tumour, but also the constitutional and other conditions, including profound anæmia, which Dr. Noble has referred to.

Dr. Noble has said in his paper that the penetration of the capsule of a fibroid by adjacent carcinoma is very rare. On the table is a specimen of mine in which that invasion is manifested. There is a distinct passing in of the carcinomatous tissue into the myomatous growth. I admit that the condition of sarcomatous degeneration does occur, but it is very rare.

Another point I wish to allude to is borne out by a specimen of mine on the table, where there is a tumour resembling adeno-myoma of the uterus, in which there is complicating it adeno-myoma of the ovary. And so closely does that assume malignant characteristics that a special Committee was appointed to investigate it. The decision arrived at was that it was adeno-myoma. It illustrated another serious consequence of myoma. When a woman arrived at a certain time of life, if she has pain in walking and on taking exercise there ensued a deterioration of her general health, and thus in a certain proportion of cases of myoma the first thing the woman complains of is that she cannot walk. The patient in question had such pain in the hip that there was a strong suspicion of joint disease. The myoma was discovered. The adeno-myomatous ovary was found at operation jammed down on the nerve, causing the pain and lameness.

In regard to cardiac complications it is right to

mention that a Fellow of the Gynecological Society fifteen years ago drew attention particularly to the complications of myoma with cardiac conditions, namely, Dr. Bedford Fenwick, in a paper which he wrote on the subject.

Another very important matter which is often forgotten in connection with these tumours is the question of mistaken diagnosis. It is all very well to take it for granted that a myoma when it occurs is always diagnosed; but in many instances it is not correctly differentiated or diagnosed. Other tumours are constantly mistaken for myomata, and by the most experienced gynecologists. Sarcomatous and carcinomatous ovaries had often been mistaken for myomatous tumours, and thus, under the idea that the tumour is harmless, interference is postponed until operation becomes impracticable, or possibly death intervenes to settle the question.

I believe the crucial point is not the percentages which can be brought forward by an operator to show his skill and the ease with which such tumours can be removed. These are now matters of ancient history. What we have to decide is our attitude to the treatment of these growths in consequence of the pathological fact which cannot be denied, that many of the tumours contained in themselves or in their complications, the inherent elements of future death, or at all events of invalidism, of misery in life, to many of torture, and the rendering of the woman useless to herself, useless to her family, and useless to society. Such a woman is an opprobrium to the surgical art.

## Clinical Records.

### BRADFORD UNION HOSPITAL.

NOTES ON A

#### *Case of Idiopathic Gangrene of Penis.*

By JOSEPH BEARD, F.R.C.S.E.

In November of last year I admitted a man, Robert C., æt. 52, into this hospital, suffering from lobar pneumonia. He was extremely ill and disinclined to answer questions.

On examination I found him suffering from acute lobar pneumonia of right lung, and in a very weak and collapsed condition, his heart sounds being scarcely audible, breathing very difficult and shallow, with anæmia in active condition. Temperature 101° F, pulse 100, hard, small, and irregular. Respiration 30 per minute. On further examination I found that he had something wrong with his penis, which he said began to go black five weeks before and began to burn and pain him when he passed urine.

This organ was now in a state of total dry gangrene, black and shrivelled up, and close to the putes was a well-marked line of demarcation which above and at the sides had ulcerated through the skin and areolar tissue down to the corpora cavernosa. On the under aspect, where it was somewhat moist with the passage of urine over it, the ulceration had extended through the corpus spongiosum and through the urethra. I passed a catheter through the proximal portion of the urethra into the bladder and drew off 3 ozs. of urine, which had a specific gravity of 1015, and contained albumen and sugar and was acid in reaction.

Next morning his condition was worse, and he was in a semi-comatose condition in spite of treatment.

At noon I infused 50 ozs. of saline solution into his median basilic vein. He rallied for a couple of hours, and then died comatose.

I obtained permission for a post-mortem examination, which revealed extensive degeneration of arteries chiefly. In fact, with the exception of the cerebral arteries every visible artery was markedly calcareous, and on dissecting out the dorsal arteries of the penis they were extremely tortuous and reduced to mere brittle cords, which broke when touched.

The pneumonia was verified, and the heart was soft and



toneless. The liver was the organ showing most change of a pathological nature, being hard and fatty, weight 70 ozs. The bladder was very enlarged, and easily held 60 ozs. of water. The other organs were in fair condition. Pancreas was perfectly normal to the naked eye.

I should mention that the man told me that for some months he had been passing large quantities of water, and that he was always thirsty.

Death in this case, of course, was due to heart failure, secondary to the acute pneumonia, but that would not account for a gangrene of the penis of five weeks' duration, and if asked for the solution I should say that the gangrene of the penis was due to the arterio-sclerosis following upon diabetes mellitus.

True idiopathic gangrene of the penis is a very rare disease, and Demarquay, who specially directed attention to it, found but few instances of it in the records of surgery.

Gangrene is not uncommon in diabetes, and is associated especially with arterio-sclerosis. Wm. Hunt analysed 64 cases, and in 50 the localities were as follows:—Feet and legs, 37; thigh and buttock, 2; lungs, 3; nucha, 2; external genitals, 1; fingers, 8; back, 1; eyes, 1.

## Transactions of Societies.

### BRITISH GYNÆCOLOGICAL SOCIETY.

MEETING HELD JULY 11TH, 1901.

The President, Dr. J. A. MANSSELL MOULLIN, in the Chair.

#### EXHIBITION OF SPECIMENS.

THE PRESIDENT drew attention to a number of interesting specimens brought together by Dr. Macnaughton-Jones, and exhibited in reference to Dr. Noble's paper. The collection included tumours which had undergone calcareous, cystic, mucoid, and teleangiectatic degenerations, others which were entirely œdematous, or into which hæmorrhage had taken place, several complicating pregnancy, and several in which, in addition to the myoma, a carcinoma, sarcoma, or cysto-sarcoma was present.

Dr. CHARLES P. NOBLE, of Philadelphia, read a paper on

#### THE COMPLICATIONS AND DEGENERATIONS OF FIBROID TUMOURS OF THE UTERUS,

which we published in full last week.

Dr. MACNAUGHTON-JONES then opened a discussion on the paper. His remarks will be found on p. 111 of our present issue.

Mr. BOWREMAN JESSETT, who followed, remarked that the Fellows of the Society were much indebted to Dr. Noble for having come to this country to deliver his admirable address. While not by any means advocating the removal of all myomatous tumours, he (Mr. Jessett) could not help thinking that the excessive conservatism of some leading obstetricians was detrimental to the best interests of women. Four years ago he curetted an uterus, and the material removed from the fundus proved to be carcinomatous. He then removed the growth, which had not since recurred. The patient in this instance had suffered for two or three years from successive hæmorrhages, and yet had been assured, or at any rate encouraged to believe by more than one obstetrician in a leading position, that the tumour would disappear at the menopause. In skilled hands the mortality after operation for myomata should be less than 5 per cent., and he thought that this low rate of mortality was in part due to the late Mr. Lawson Tait, inasmuch as he first ceased the indiscriminate administration of opium, and gave an aperient two days after operation. With regard to complications, he had seen a case of appendicitis closely simulate ovaritis, but he had never seen the former as a complication of myoma. He could not agree with Dr. Noble as to the rarity of sarcoma. He had at least four specimens showing the presence of sarcomatous cells, two of which were before the Society. As

to carcinoma, he had not seen more than two or three cases, and was inclined to think that where present with a myoma there was no relationship between them. The question of pregnancy might be a very serious one. On one occasion on which he found two large fibroids, and suspected pregnancy, he advised the woman to postpone any active interference. Three weeks later the patient was taken suddenly ill, had a severe rigor, and appeared in great danger. He performed hysterectomy and found a fetus present, with two fibroids. The patient made an excellent recovery. He would remark, however, that if the patient goes to full term and is delivered safely, the fibroid becomes reduced in size. When operation was necessary he considered the removal of the uterus to be preferable to abortion. The question of the effect of the menopause had been worn threadbare. In a few cases tumours decrease in size, while in some they undergo a marked increase. There were two other points which should be borne in mind when considering the advisability of operation—the social position of the woman and the situation of the tumour. A tumour might incapacitate a poor woman from obtaining a livelihood and consequently call for operation, whereas in the case of her wealthier sister it might occasion inconvenience only. Sub-peritoneal fibroids grew less quickly, and caused less urgent symptoms than those of submucous or intra-mural origin, and therefore rendered operative interference less necessary. When, however, severe hæmorrhage occurred, the patient became anæmic and lost strength, or sepsis supervened, operation should be resorted to as early as possible.

Mrs. SCHARLIEB believed that a certain number of fibro-myomata did decrease in size at the menopause, yet waiting for that event, and the very problematical benefits produced by it involved serious risks. In this connection she quoted the case of a lady, considerably over fifty years of age, with an apparently quiescent myoma reaching to the level of the umbilicus, who had consulted her twelve months or more previously. The patient had passed the menopause and was in a fair state of health. She promised to return in a short while, but failed to do so. Recently she had been called to her in response to an urgent summons, and found her suffering from pleurisy, thrombosis of both femoral veins, and severe abdominal pain and sickness. Her pulse was rapid and her temperature 102° to 105°, her whole condition indicating that there was considerable septic absorption, and being such as to render immediate surgical relief hardly practicable. After the lapse of a month her condition had somewhat improved, and Mrs. Scharlieb removed the myoma which contained several cavities filled with offensive fluid. The patient made a complete though tedious recovery, and Mrs. Scharlieb regretted she had not advised operation when she had first been consulted. As to age, Mr. Noble's youngest patient was 17. She had removed with Mrs. Stanley Boyd, a tumour from the anterior wall of the uterus of a girl, æt. 14, brought the edges of the incision in the muscle together, and left the patient with her uterus, ovaries, and tubes complete.

Mrs. STANLEY BOYD referred to the great difficulty of determining the original nature of a tumour said to have undergone sarcomatous degeneration, especially in hospital patients who usually came with a tumour already large. For example, a patient, æt. 50, recently came under her observation with a large tumour producing severe hæmorrhage. From the fact that it had first appeared six months after the menopause, and from the rapidity of growth, it was suspected to be of a sarcomatous nature, and such it proved to be. In such a case it was not possible to say whether the growth was sarcomatous *ab initio*, or had been a fibroid at an earlier stage, and had recently become sarcomatous, and, consequent on the change, had grown rapidly and become evident. Curetting she regarded as an extremely unsatisfactory method of arresting the hæmorrhage produced by a fibroid. Its effects were never permanent.

Dr. HAYWOOD SMITH thought that fibroids did undoubtedly decrease after parturition, though possibly there was an initial increase during pregnancy. He thought the surgeon might with advantage avoid inter-

fering were pregnancy a probable contingency, and if the uterus were not much enlarged, or if the tumour were flattened. Curetting should be entirely suppressed in cases of fibroid tumour.

Dr. HERBERT SNOW said there were four ways in which a fibroid tumour of the uterus might be related to malignancy, only one of which could properly be spoken of as a process of degeneration. A tumour might be of the soft, solitary, œdematous variety. These began at an early age, were always attended by hypertrophy of the uterus, and in their later stages by an immense secretion of serum, so that the tumour on section lost about one-fourth of its bulk. At the last meeting he had suggested the term "monoma" for such tumours. They were malignant from their first appearance, inasmuch as, though not of a sarcomatous nature, they invariably proved fatal in a comparatively short time, unless removed. Then there was the common, hard, multiple fibroid, which in a few rare instances became myo-sarcomatous. Such a change might truly be spoken of as degeneration. Thirdly, a myoma might be present, merely as a coincidence, in a uterus in which there was a carcinoma. Lastly, a myoma might, by the irritation and congestion which it produced, induce the development of carcinomatous disease. In reference to the causes of death, he agreed with Dr. Noble and Dr. Macnaughton-Jones as to the importance of early operation, and of not relying upon any beneficial results which might follow the menopause. At the same time he would point out that a number of corpulent women of advanced age had multiple myoma which apparently produced no symptoms.

Dr. MACPHERSON LAWRIE believed that fewer operations would be performed for myoma uteri in years to come than at the present time, though in poor women he quite agreed that operative measures might be more frequently necessary.

Mr. SKENE KEITH pointed out that when a fibroma was present the menopause rarely took place before the age of 54. He was convinced that fibrous tumours did diminish in size after pregnancy. He recommended operation in a certain number of cases, but he held very strongly that the majority of fibrous tumours of the uterus did not require operation.

Mr. STANLEY BOYD said that the etiology of certain complications was obvious, as for example, necrosis, and other changes described as taking place in fibroid tumours. Again, inflammation might easily spread from the uterus to the Fallopian tubes, and endometritis be followed by salpingitis, the contents of the tube becoming subsequently infected with pyococci or the bacillus coli communis. But such a condition as cancer could hardly be regarded as a complication, it being of epiblastic origin, while fibro-myomata were of mesoblastic. Though it was conceivable that the irritation produced by a myoma might give rise to cancer, he did not believe that increased vascularity tended to do so, seeing how very much more vascular other regions were without increased liability to such a change. No developmental difficulty presented itself with regard to sarcomatous degeneration. Mesoblastic tissue already growing abnormally might, without violating the laws which embryology seemed to have established, become malignant in nature.

Dr. NOBLE, in reply, said that one point he had endeavoured to emphasise by his paper was that a fibroid tumour should not be regarded as an isolated entity; but in conjunction with the many complications with which it was in a large percentage of cases associated. He did not maintain, and it was not his object to establish, that if a woman had a fibroid she necessarily developed appendicitis, ovarian disease, cancer, etc., but merely that in his experience, and as far as he could ascertain, in the experience of others who had equally carefully recorded their cases, in any 100 cases in which fibroid tumours were taken just as they presented themselves without selection, some other disease would be present, and that that fact had a very material bearing upon the line of treatment which should be followed. He agreed with Dr. Macnaughton Jones that where a fibroid tumour had been long present, and the patient anæmic,

the mental condition of the patient was not normally stable. He thought the term "expectant" should replace the word "conservative" as applied in gynecology. As to sarcomatous degeneration it was a question for pathologists to decide, but he had been assured by those in whom he reposed much confidence, that true sarcomatous degeneration was very rare. He quite agreed with Dr. Heywood Smith's remarks on curetting, and regarded it as palliative at best.

## France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, July 28th, 1901.

### OPHTHALMIA NEONATORUM.

At the Académie de Médecine M. Pinard read a paper in answer to a circular received from the Government on the prophylaxis of ophthalmia in new-born infants, in which, after developing the subject, he proposed the following resolutions to be approved by the Académie:—

1. To distribute in all the town halls, with the birth certificate, a short notice indicating the causes, symptoms, and dangers of ophthalmia of infants.

2. To take measures for the immediate notification of purulent ophthalmia everywhere, and in every case.

3. To attach to all the maternity hospitals and clinics oculists charged with the direction of the treatment of purulent ophthalmia, and the instruction in the affection of students, doctors, and midwives. (Adopted.)

### TREATMENT OF JUVENILE ACNE.

Bicarbonate of soda, grs. vj;  
Calcined magnesia, grs. iv;  
Powder of cascara sagrada, grs. iij;  
Benz. naphthol, grs. iij.

For one wafer. Two a day at meal times.

Naphthol B., grs. vj;  
Resorcine, grs. iv;  
Savon noir, grs. iv;  
Prepared chalk, grs. x;  
Sublimated sulphur, grs. xxx;  
Vaseline, ʒvj.

To be used at night.

Each morning pass over the face—

Borate of soda, ʒiij;  
Camphorated sulphuric ether, ʒij;  
Eau de roses, ʒix.

### CACODYLIC MEDICATION.

M. Gautier read a paper on the above subject, in which he established that the preparations of cacodylate of soda administered by the hypodermic method rendered good service in consumptive affections such as pulmonary tuberculosis in the first and second stages, osseous tuberculosis, diabetes, neurasthenia, chronic paludism, pronounced anæmia, &c.

The principal counter-indication to the use of the drug lay in hepatic affections, cancer, congestion, hypertrophy, jaundice, cirrhosis.

The symptoms of interference were intermittent congestion of the face, sensation of pain in the abdomen, rarely fever.

In women the cacodylic treatment hastens the return of the menses and renders them more abundant. Sometimes even metrorrhagia is provoked if the agent is not suspended four or five days before the appointed time.

One of the surest signs that the proper dose has been exceeded is the noises in the ears complained of by the

patient. The cacodylates can be employed for any length of time provided they be suspended from time to time. They acted by exciting the reproduction of the cells in multiplying the hematin, in rejuvenating the tissues, and in conferring on the economy an extraordinary resistance to morbid affections.

Amongst the adjuvants of cacodylic medication iodides take first place. The speaker advised the administration to the patient an hour before dinner a dessert spoonful of a solution containing one drachm of chloride of sodium, fifteen grains of iodide of potassium and of bromide of potassium in three and a-half ounces of water.

### Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, July 27th, 1901.

In the *Archiv. f. Gyn.*, Bd. 63, C. Menge has a very practical article on the

#### TREATMENT OF CHRONIC ENDOMETRITIS IN GENERAL PRACTICE.

He believed the reason why this disease is so much neglected by the general practitioner lies in the want of technical dexterity. The writer was led by this conviction to search out a method of treatment that would be equally useful in all forms of the disease, that would be as free from danger as possible, and that would demand the least possible amount of manual procedures. The treatment should admit of being carried out rapidly in the consulting room, and without previous dilatation of the cervix. After touching upon the usual methods of treatment, he proceeded to describe that practised by himself, which in the course of years has proved to answer all the requirements both on the side of the general practitioner and of the patient. A solution of formaline, from 30 to 50 per cent. in strength, has proved a useful and non-painful intra-uterine application. For the purpose of applying such a solution he has had constructed a smooth, hard rubber sound, thinner towards the end, armed with a thin layer of absorbent cotton to a distance of 40 ctm., and kept for use in a cylinder filled with the formaline solution. The caustic is never applied after a bimanual examination, but always some days afterwards. It is applied in the following way: A freshly boiled Trelat or Neugebauer speculum is introduced into the vagina. After the os is found it is wiped with a pledget soaked in perchloride solution. The anterior lip of the uterus is now hooked for the purpose of steadying it—not to draw it down. Two or three formaline sounds are now introduced one after the other and passed in all directions, so that the bottom of all the folds of mucous surface shall be reached. A strip of gauze is now introduced for the purpose of draining the cavity of superfluous fluid. In the early part of the treatment it is best to wait until the mucous surface is renewed before applying the caustic a second time. Later on, however, it may be applied at intervals of a week. The formaline caustic had a beneficial effect in chronic endometritis whether following labour or abortion, provided that no placental remains were in utero. These should not be burnt off with the caustic, but after one or two applications they should be removed with the cuvette. Post-gonorrhoeal endometritis may often be cured in this way after very

few applications, provided general treatment be kept up at the same time. If, on the other hand, the endometritis is due to general disturbance, but little is to be expected from local treatment. There must be a rational combination of general and local treatment in some cases. He mentions the contra-indication to the treatment, which will be obvious to anyone who gives the matter a thought. When there is malignant change in the endometrium the treatment is inadvisable.

### Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, July 27th, 1901.

#### KNEE-JOINT CONTRACTIONS AND ANKYLOSIS.

At the meeting of the "Naturforscher" Lorenz gave his experience of 300 cases which had been treated operatively for correction of knee-joints by rational orthopedics. There are two fundamental principles which he considers should always be kept in view—correction of the vertex of the deformed angle and rigid protection of the skeletal parts, even at the cost of the soft tissues. In straightening the limbs he prefers the use of a caoutchouc upholstered plate or pad—"Lorenz Redresseur." This instrument is fitted on to the lower part of the femur, the padding stops at the knee-joint; from this a fixture passes on to the tibia, and is also, by means of a screw, slowly pressed outwards and downwards until the leg is straight. This usually termed central correction.

When the injury is eccentric and much of the soft tissue destroyed, the correction may be effected more rapidly, gradually altering the apparatus every three quarters of an hour. He summarises the advantages of this operation as: freedom from danger; retention of all the skeletal strength, easy locomotion, as well as a final mobile joint. During the last five years he had treated 300 contracted and ankylosed knee-joints with the best results.

In the discussion that followed Muller expressed surprise that Lorenz never speaks of having awakened new inflammatory action in a joint that has been quiescent, as most of these ankylosed joints occur in strumous or tuberculous patients prone to this new evolution.

Lorenz replied by saying that his practice was not to touch a joint until all inflammatory action had ceased.

#### LUXATIO PATELLÆ.

At the same meeting Bardenheuer described his mode of procedure when the patella became habitually luxated. He lays the knee-joint bare without opening it. By a crescentic incision the capsule is opened on the inside, the ligamentum patellæ proprium is divided, while the posterior part of the capsule is drawn forward over the anterior portion and fixed with a suture, while the whole is finally attached to the vastus internus. The inner margin of the biceps tendon is often turned over and fixed, thus shortening this muscle also.

Trendelenburg thought that most of the habitual luxations were congenital, particularly the genu valgum, which was best treated by McEwen's operation. In one case recently, after trying many remedies, he found the tuberosity of the tibia with the ligamentum patellæ, and finally made a groove with the chisel over the front of the external condyle, into which he drove an ebony

wedge. He is unable yet to say what the final effect may be, although the method answers well at the present.

#### INJURY TO THE CENTER OF SPEECH.

Longard showed two cases to the meeting where complicated fractures of the left parietal bone had taken place two to three centimetres above the ear. In the first case speech was almost lost for fourteen days after the injury, which might correctly be termed monophasia, as every question was answered by "Bitte, Bitte," the patient having no power to say more. For six weeks after the accident he gradually improved, so that after that time speech had so far recovered as would lead a stranger to believe that nothing had occurred. No paralysis or other untoward symptom was present, which was strange after losing upwards of a tablespoonful of brain matter from such an important part of the brain as the central convolution. At the time of exhibition nothing defective could be observed.

The second case had slight paresis of the right upper arm and a little spastic step, motor aphasia, and agraphia. Three weeks after the accident he suffered from traumatic delirium, which soon passed off and has left him perfectly well.

#### CYSTS IN OVARIAL REMAINS.

Fischer and Waldstein in Schauta's clinic have recently drawn attention to the frequency of cysts forming in the remains of the adnexa after tubes and ovaries have been carefully removed. Fischer relates a case as an example where both tubes and both ovaries were carefully removed. The following year he had to remove a cyst about the size of his fist, and one from the right side the next year.

Waldstein records four such cases of his own that had to be operated on again at different periods after the primary operation for cystic recurrence. It has been observed that these remnants have power sooner or later to develop cysts until perfect atrophy has destroyed cystic degeneration.

#### LIGATURES AND SUTURES.

Catgut has not given the satisfaction to surgeons that would inspire confidence, hence the search for some substitute. Katzenstein has introduced an instrument for applying silver wire in the form of rings, for which he claims many advantages.

Greife, of Moscow, has discovered that the hair of the reindeer is perfectly germ free, and an excellent substitute for catgut. To remove the fat the hairs are placed two days in ether, subsequently in oil of juniper, alcohol, and sublimate.

### Special Article.

#### THE CONGRESS ON TUBERCULOSIS.

THE organisers of the Congress which ran its normal course last week may be congratulated upon having done their work well. The whole machinery moved smoothly and we have heard no complaints of short-comings, not even from our fellow preesmen, who are usually, and not unreasonably, prone to criticise. Professor Koch's paper, which we publish elsewhere, on the non-identity of bovine and human tuberculosis had for effect to throw into the shade many valuable contributions dealing with, or based upon, the views which the eminent pathologist has challenged. It is obviously idle to discuss the degree of infectivity of milk and meat

at a time when the infectivity itself is called in question, nor do measures for sterilising, or preventing the sale of, such aliments commend themselves for discussion when, it may be, they will shortly be proved to be unnecessary. In the feeling of surprise at Professor Koch's unexpected announcement, which will remain the *clou* of the Congress, one is apt to exaggerate the importance of the point at issue. Whether the bovine disease be communicable to man or not, no one doubts that man to man infection is by far the most important means of propagating the disease, and we must act accordingly. We were possibly in danger of overlooking the vastly greater scope of human infection in our endeavours to prevent contamination of animal origin.

Now at any rate we have no excuse for failing to grapple the problem in a scientific spirit. We know that the expectoration of tuberculous subjects is the prime source of infection, and it is for us to devise plans for depriving this agency of its lethal power. The plan of campaign comprises several general principles and a number of precautions of detail. An united effort must be made to prevent promiscuous expectoration, less by repressive legislation, which would be difficult to obtain and still more difficult to enforce, at any rate so far as the streets are concerned, than by impressing upon the public the benefit to the community which would accrue were this disgusting habit voluntarily put a stop to. The next point is to remove phthisical patients of the working classes from their unsanitary surroundings, partly with a view to preventing the spread of the disease to other members of their families, partly also with a view to their cure. We must bring our influence to bear upon our consumptive patients to induce them to prevent their becoming a source of danger to the community. This can be done by telling them what to do and what not to do, and also by furnishing them with a portable spittoon. These recommendations, so far as they go, will commend themselves as easy of application and of undoubted efficacy. When, however, we come to consider the conditions under which human beings fall a prey to the disease we are confronted with difficulties of another order. Susceptibility to tuberculosis may be inherited or acquired. Hereditary predisposition may be minimised by careful attention to the laws of hygiene, but there remains the fact that the circumstances and conditions of labour of the labouring classes, at any rate in our large cities, are often such as to favour the evolution of the disease. Overcrowding, want of cleanliness, alcoholism, imperfect ventilation, &c., all tend to depreciate vitality and so throw open the doors to infection. Here we are face to face with a problem of such immensity and complexity as to discourage all but the most robust. Legislation has done much to ameliorate the conditions of life of the working classes, but how much more remains to be done! Still, though it may not be possible to cleanse the Augean stables forthwith, it behoves us to attack the problem resolutely and persistently. The danger is not confined to any one class of the community, for society may be likened to an organism which suffers as a whole when one of its organs is diseased.

Among the questions discussed was the system of voluntary notification of cases of phthisis. Obviously it would be idle to adopt notification unless this step

were to be the prelude to further steps. And what are these steps? Apart from the fact that a knowledge of the local distribution of phthisis would call public attention to the prevalence of the disease in certain areas, thus inviting more efficient sanitary inspection, it would enable the sanitary authorities to give advice as to the sterilisation of the sputum, and to secure the removal to sanatoria of those whose circumstances are such as to preclude adequate care at home. It would enable them to insist upon thorough disinfection of the premises and the remedying of obvious sanitary shortcomings. The opinion of Congress was in favour of its adoption wherever it was practicable to take the consequential measures.

There was a good deal of discussion on the question of compensation to breeders and others for the slaughter of animals recognised to be tuberculous, but in future it is probable that only animals suffering from general tuberculosis will be condemned, in accordance with the general principle that the meat of diseased animals shall not be sold, so that the question of compensation will hardly be brought forward. The owner of a diseased animal cannot expect to be recuperated from public funds any more than he himself would claim compensation when from illness he is unable to attend to his business.

Incidentally attention was called to the importance of providing better accommodation for cattle. They, like human beings, suffer from overcrowding, inadequate ventilation, and insufficient nourishment. The importance of the segregation of infected animals is as important with animals as with human beings. It is to neglect of cattle hygiene that we owe the fact that over half the total number of cows in this country suffer to a greater or less degree from tuberculosis. That is a deplorable fact from a merely commercial point of view, and breeders of animals must be made to understand the importance of maintaining their cattle in a good state of health quite apart from any question of their communicating their disease to human beings.

The concluding general meeting took place on Friday, when a number of resolutions were agreed to. (1) Recognising the extremely infective nature of tuberculous expectoration, and in favour of suppressing promiscuous expectoration; (2) urging that patients with phthisis should be provided with a portable spittoon and given printed instructions of the precautions they should take; (3) affirming the good results to be obtained by voluntary notification if utilised to prevent the spread of the disease; (4) recognising that the provision of sanatoria is an indispensable part of the measures necessary to the diminution of tuberculosis; (5) urging medical officers of health to continue their efforts to prevent the spread of tuberculosis by meat and milk, (6) urging the Government to set on foot an inquiry in view of the doubts thrown on the identity of human and bovine tuberculosis. Passing over several resolutions of subsidiary importance the Congress recommended the creation of a permanent International committee to co-ordinate the labours of the various bodies having for object the advancement of the cause.

The Congress indisputably owes much of its success to the cordial support which His Majesty has given to the movement. The foreign delegates were received by His Majesty at Marlborough House on Thursday last, when he thanked them for their co-operation in the good

work, and called their attention to the fact that cancer was another fell disease which had so far baffled the scientific and medical men of the world.

Every evening during the week there was some function of interest to occupy our distinguished visitors. On Monday the President of the Council, the Earl of Derby and the Executive Council held a reception. On Tuesday the Lord Mayor and Lady Mayoress received the members and delegates at the Mansion House. On Wednesday evening the Countess of Derby and the Ladies' Reception Committee gave a garden party at the Royal Botanical Gardens. On Thursday Lord and Lady Derby had a reception at the Victoria and Albert Museum. On Friday afternoon Sir J. Whittaker Ellis invited the members to a river party at Richmond; while on Saturday afternoon, as a graceful close to the proceedings, the Duke and Duchess of Northumberland gave a garden party at Syon House.

## The Operating Theatres.

### ST. THOMAS'S HOSPITAL.

MR. BATTLE'S OPERATION FOR FEMORAL HERNIA.—Mr. BATTLE operated on a young man, *æt.* 21, for the radical cure of left femoral hernia. There were many unusual circumstances attending the case, which rendered a diagnosis of the swelling difficult. The patient stated that he had noticed the tumour suddenly about two years before, that it was the same size then as it was on admission, that it had not varied in size on any occasion since it had appeared; he had had no pain or discomfort about it, and in fact it caused him no inconvenience. The tumour, situated in the left groin, occupied the femoral region, it was flattened, of somewhat irregular outline, appeared lobulated, and had a fairly defined margin. One or two enlarged glands could be felt near, but there was no distinct fluctuation in the swelling itself. It did not vary with the position of the patient, it could not be diminished in size by pressure, and there was no impulse on coughing. When first examined the impression given was that of a chronic abscess of the glands in the groin; but its duration was against this; moreover, the sense of fluctuation was not clear. Then the question of fatty tumour had to be considered; the swelling resembled a fatty tumour in many ways, but it was not thought to be one from the want of distinct lobulation and the age of the patient. The duration of two years was against *nævo-lipoma*. After the patient had been in hospital for a few days the swelling appeared to become softer, and it was possible to feel that there was an attachment in the position of the saphenous opening, and although the feel was that of a fatty tumour, the texture appeared to be more loose. There was still no impulse on coughing, nor could any difference in size be produced by taxis. The opinion expressed before operation was that the tumour was probably a hernia in spite of the unusual occurrence of a femoral hernia in a young man of this age. This proved to be the case, for when a vertical incision had been made over the swelling a hernial sac was reached, but was found to contain nothing but omentum. This was reduced into the abdominal cavity, the sac dissected up and ligatured at its neck. The upper part of the incision was retracted, and the operation continued as follows:—An incision was made through the aponeurosis of the external oblique

from the external ring outwards; the lower pillar of the ring was then separated from the cord down to Poupart's ligament and the femoral ring, the neck of the sac was then freed from the ring and brought above Poupart's ligament, the ligature round its neck was cut short and the body of the sac cut away; the internal pillar of the ring and the cut aponeurosis continuous with it was brought down and sutured by means of three sutures to the fascia over the Pectineus behind the femoral canal, to Poupart's ligament on the outer side, and to Gimbernat's ligament on the inner side; the external pillar of the ring was then sutured to the internal pillar and aponeurosis which had been passed behind. A stitch was placed outside the femoral canal to approximate Poupart's ligament to the fascia of the Pectineus. The femoral ring was unusually large, admitting two fingers. The external wound was closed in the usual way. Mr. Battle said the case was an unusual one from the fact that this form of hernia was extremely rare at this age in a male; he had once had to do a radical cure for a boy, *æt.* 16, with a femoral hernia, and in both that case and the present one the cause of the hernia was probably the same, namely, want of development of Gimbernat's ligament. The hernia also, he pointed out, was unusual in its characters, as was shown by the history and by the absence of most of the signs which are relied upon for the diagnosis of any hernial protrusion. The only definite things were: the presence of a swelling in the femoral region which had apparently become softer whilst the patient had been under observation, the feeling of omentum conveyed to the fingers, and the difficulty in moving it from the femoral region. It has, he said, been noted that the femoral opening was large, and it was necessary to use some method of cure that could be relied upon to act in the case of a man who would be called upon to do hard work. The method employed fulfils the purpose, the sac is obliterated, and between the ligatured neck and the upper part of the femoral canal a shutter of strong fibrous character is interposed, and any traction which might be made on this shutter during extra exertion is transferred from the outer margin of the external ring, and aponeurosis to Poupart's ligament. The extra stitch which closes the femoral ring is possibly unnecessary but helps to consolidate the parts outside the canal.

The patient made an uninterrupted recovery.

**TWO OPERATIONS FOR EPITHELIOMA OF THE LIP IN THE SAME PATIENT.**—The same surgeon operated on a man, *æt.* about 50, for epithelioma of the upper lip and cheek on the left side. The growth was of some size, extending for about an inch and a-half inwards from the left angle of the mouth. It was typical in appearance. About an inch above it there was a raised, red portion of cheek which was very hard, and above this near the angle of the nose the skin was broken and a small malignant ulcer was forming. The glands underneath the jaw in the left side could be felt, they were evidently diseased. The mouth was small as the result of a former operation two years ago for the removal of an epithelioma of the right half of the lower lip; the scar of that operation was healthy. When Mr. Battle operated for epithelioma of the upper lip on the present occasion the operation was necessarily rather extensive; he removed the glands under the jaw in the

first place through a long incision parallel with and below the lower margin; he also divided the facial artery so as to diminish bleeding in the second stage. The tumour of the lip and cheek was removed by means of two incisions, which formed an oval, and extended about half way up the side of the nose and laid bare the upper jaw. The stitches when inserted pulled on the cheek so as to raise considerably the upper margin of the submaxillary incision, but the loose skin of the neck was brought upward, and united without tension. The operation made the mouth very small, therefore an incision was made to the right from the angle of the mouth for half to three-quarters of an inch, and the mucous membrane stitched to the skin. Mr. Battle stated that it was unusual for epithelioma to show itself in more than one place on the lips, and it was curious that this man should have allowed the growth to reach the large size it had done, because the previous operation had been a severe one simply because it was done for a large growth. The probability was thought that he had been induced by his friends to try some so-called cure. Epithelioma of the lip, he pointed out, if taken early can undoubtedly be cured.

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## The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, JULY 31, 1901.

### PROFESSOR KOCH ON BOVINE AND HUMAN TUBERCULOSIS.

THE announcement of an address on a subject so peculiarly his own by the justly celebrated German bacteriologist was an important item on the programme of the Congress on Tuberculosis, and it did not fail to attract a large and appreciative audience. The address itself, though characterised by the persuasive decision of an investigator who is dealing with facts within his own knowledge, came upon the audience like “a bolt from the blue.” Hitherto the problem of preventing the spread of pulmonary tuberculosis has been based in very great measure upon the assumption that human beings are infected to an unknown but presumably considerable extent by the ingestion of contaminated articles of food, notably the milk and flesh of diseased animals. In other words, it has all along been assumed that tuber-

culosis in man and animals is one and the same disease, and as the process of restricting the sale of infected food presents vastly less practical difficulty than that of preventing its spread from man to man, a huge superstructure of preventive measures has been erected on this basis. Judge then of the surprise which was felt when Professor Koch calmly asserted that bovine tuberculosis is distinct from human tuberculosis, that the disease cannot be transmitted from man to animals nor, inferentially, from animals to man; in fact, he regards infection by the milk and meat of tuberculous cattle and the butter made of their milk as a negligible quantity. It is impossible not to experience a shock at this bold attack on a series of conclusions which we fondly thought had been definitely established, thanks to the costly researches of two Royal Commissions fortified by independent observations from all parts of the world. The non-transmissibility of human tuberculosis to animals Professor Koch claims to have clearly demonstrated, but he is less emphatic with regard to the possibility of the transmission of bovine tuberculosis to man, simply because direct experiment could not be resorted to. It is obvious that conclusions of this far-reaching importance cannot be accepted without the closest scrutiny. The prevalence of intestinal tuberculosis among infants, presumably of alimentary origin, certainly suggests possible infection by contaminated milk; but in regard to this question, M. Koch's statistics are strikingly at variance with our own. Before discrediting the conclusions embodied in the Report of the Royal Commission, it behoves us to await further independent inquiry. In the meanwhile we must refer our readers to the address delivered by Professor McFadyean, an abstract whereof we publish elsewhere. This is virtually a reply to Professor Koch's indictment, and although it does not invalidate his conclusions it shows that there are many and weighty reasons for suspending judgment. It is hardly necessary to point out that even if the non-transmissibility of human tuberculosis to animals had been placed beyond the reach of criticism, it by no means follows that the converse is true, viz., that the tuberculosis of animals is not transmissible to human beings. It would seem that the tuberculosis is a more virulent disease in animals than in man, and it is conceivable that in passing through human beings it undergoes attenuation, to such an extent indeed as to render its retransmission to cattle difficult though not impossible. The question, so far as it relates to the amenability of human beings to infection by the germs of animal tuberculosis, will have to be worked out in the light of clinical observation, a process which presents considerable difficulty and no small degree of uncertainty. Professor Koch deserves credit for having had the courage to proclaim such heterodox views, and whatever conclusion we may ultimately come to with regard to their accuracy he will have rendered the immense service of having called attention to the vastly greater import-

ance as a factor in the dissemination of tuberculosis of man to man infection. In our anxiety to stamp out alimentary tuberculosis it may be that we were on the point of going off on a false scent, false in the sense of attaching thereto an importance in excess of its merits. This Congress will be memorable in the history of the movement in that the rudder has been shifted and we have been invited to rectify an error of direction.

#### A NATIONAL CONCERN.

THE continued destruction of our army in South Africa by enteric fever and dysentery is a subject of vital national importance. It is with the object of remedying this destruction that a Committee of hygienic experts are at present holding an inquiry in South Africa. This subject is a highly interesting one, and forms the theme of a recent publication by Dr. Leigh Canney, of London. (a) That the death-rate from these diseases in the present war has been far greater than from all other causes put together none will deny. It is apparent to any observer of the weekly casualty lists. Enteric fever and dysentery have from time immemorial been the scourges of all armies in the field, and there was no reason to expect their absence in this campaign. In fact, it was known for a long time before the outbreak of hostilities that enteric fever was endemic in South Africa. The Army Medical Department fully recognised this, and expected epidemics of it at certain periods of the year. The relationship between the Army Medical Department and the War Office is a peculiar one. In the event of any war being threatened, the Adjutant-General communicates with the Director-General of the Army Medical Service, and informs him where the war is to take place, and the strength of troops likely to be employed. It is then the duty of the Chief of the Medical Department to submit a proposal as to the medical requirements. After this proposal has been discussed by the Army Board, the Director-General submits a memorandum showing the probable diseases likely to be encountered, the kind of supplies and the kind of provisions likely to be got, and all details connected with the sanitary part of the campaign. Having done this, the Medical Department has to wait its turn and get its recommendations sanctioned by the Army Board, on which the Director-General has neither seat nor vote—a most curious anomaly! He merely acts as a spectator and rarely reaps any benefit if the campaign is a successful one, whilst he is certain to have to bear the brunt of anything which goes wrong. Dr. Leigh Canney fully recognises this state of affairs in his recent publication "Typhoid the Destroyer of Armies and its Abolition," and brings before the public *the facts* which stand in the way of any suitable prophylactic measures being adopted against these diseases in war. He attributes the lack of preventive

(a) "Typhoid, the Destroyer of Armies, and its Abolition." By H. E. Leigh Canney, M.D. Lond. Bailliere, Tindall and Cox. 1901. 1s.

measures, not to the Army Medical Department, which advised everything necessary, but to the persons who would not act upon this advice, namely, the Commander-in-Chief at the time the war broke out. Lord Wolseley's attitude towards our professional brethren in the Army is well known. In the past it has been responsible for the difficulty of filling the ranks of the R.A.M.C., and now it would seem to have led him into even graver errors of omission. In the course of his remarks Dr. Canney says: "The danger was known and calculated upon, he (the Commander-in-Chief) made no adequate provision to meet it." Such a rôle is not surprising of the man who condemned the sanitary officer as a "useless encumbrance" in time of war. We do not, however, wish to dwell upon errors which, are, we trust, over. The future, under the control and with the sympathy of, the present Commander-in-Chief is of more practical importance. The Royal Commission on South African Hospitals has suggested what Dr. Canney now suggests, and what has been recommended over and over again, namely, the appointment of "young, able, general sanitary officers of high rank from the officers of the R.A.M.C." How often has this advice been tendered to the War Office? How often has it been ignored? Now is a suitable opportunity for reform. Mr. Brodrick's "Committee on the Army Medical Service" is sitting in London at present; let it consider this among the many reforms needed. Let them select from their officers the men most qualified for these posts, and give them some stimulus for their work—extra pay, and sufficient study leave, to keep their knowledge up-to-date. Dr. Canney suggests a scheme for sterilisation of water on field service which is worthy of the closest consideration. He has devised a machine which can supply fifty men in less than twelve minutes with fifty pints of boiling water, and this water can be cooled for drinking by a special apparatus in five minutes. His boiler fitted in a case with a cooling apparatus weighs seventy pounds. Six pints of petroleum, sufficing for four pints of boiled water daily for each of the fifty men for four days, weighs seven and a half pounds. Two such machines and double the supply of petroleum can be carried by a mule and should accompany each unit of 100 men. Further, Dr. Canney advocates the formation of a "Water Corps" to take charge of this outfit and look after all water supplies. Petroleum has undoubtedly its advantages, but its inflammable nature and the consequent danger of its proximity to a waggon laden with lyddite must not be lost sight of. Indeed, it is very questionable if any of our generals in view of grass fires and stray shells would view its introduction with equanimity. The weight of the outfit is also a cause of difficulty. Each company of a regiment would require one mule, a battalion thus requiring ten mules. As two pack mules per battalion are only allowed for ammunition, and two per battalion for machine guns, it is very questionable if the military authorities would sanction the increase

which to convey apparatus entails. It will take many years of education to win over the *laissez-boire* section of our combatant officers and men, and we are afraid that the saying "Tommy will drink when he likes," will hold good for many a campaign to come. Still, we think that even our military chiefs will some day learn that if a preventable disease can destroy an army more rapidly than the strongest enemy, it is worth their while to allow steps to be taken which will make the prevention of enteric fever an accomplished fact, instead of a subject for red tape and departmental obstruction.

#### RURAL MEDICAL OFFICERSHIPS OF HEALTH.

THERE is every reason to be proud of the position taken by the United Kingdom in the practical administration of public health matters. By common consent this country has been awarded the first place among the nations with regard to that detail whereby the vital welfare of the community is so profoundly influenced. At the same time it is necessary from time to time to review the situation and to remind ourselves of the fact that a great space intervenes between present imperfections and the future sanitary millennium. One of the most obvious matters that demand attention is the inequality of standard between urban and rural sanitation. That such should be the case is not altogether surprising when we take into consideration the differences in wealth, density of population, general enlightenment, and other essential conditions that closely affect not only the public spirit but also the centralisation and decentralisation of local government. In sparsely-inhabited rural districts it is not too much to say that sanitary administration is often of the most primitive and perfunctory character. In the majority of cases the duties of the medical officer of health are entrusted to a country practitioner who receives a small and not infrequently a paltry salary in return for his services. The conditions of such an appointment are clearly not conducive to thorough and energetic action on the part of the medical officer. His duties with regard to bad housing, bad water supply, bad drainage, defective dairies, and the hundred and one details that fall within the purview of his office are no less manifold than important. By carrying them out, however, with anything like vigour and impartiality he would find himself arrayed against landowners, tenants, members of local governing bodies, in short, against the main body of his patients, high and low, throughout the district. It would be too much to expect of frail human nature to undergo an ordeal of that kind. The usual result is that the rural medical officer of health draws his salary, and as far as possible lets sanitation look after itself. The outcome of this temporising attitude is writ large in the numerous Local Government Board inquiries from time to time upon the sanitary state of this or that rural district. Many of the plague spots thus brought to light have been described in the columns of the



**MEDICAL PRESS AND CIRCULAR.** Their existence is enough to warrant a good deal of heart-searching among those public health experts who plume themselves upon the advanced preventive standards that have been attained in the United Kingdom. There can be no doubt that the Local Government Board would be able to help on reform by insisting that in all cases an adequate salary should be paid to the rural medical officer of health, and that he should have a tenure of office not less stable than that of his urban brethren. Still more, again, would be effected by bringing pressure to bear upon County Councils to appoint medical officers for their districts. By amalgamating a number of petty rural appointments it would become possible to secure the whole services of a specially qualified and well-paid man for a county. These considerations are of the utmost importance in view of the close connection that has of recent years been recognised as existing between town and county sanitation. A large proportion of the food of the urban population comes from rural districts. Again and again has the epidemic disaster of the towns been traced to the sanitary sins of the country. In spite of Professor Koch's views, the English sanitarian will continue to believe that bovine tuberculosis lies at the root of much of the human tuberculosis that decimates the inhabitants of our cities. The rigid and systematic inspection of farms and dairies is demanded in order to protect the urban population from the great scourges of tubercle, enteric fever, and scarlet fever, not to mention others. Of late years the need of close concerted action between the sanitary authorities of town and country has been widely recognised. Obviously, however, the value of such an arrangement will depend on the strength of the combining organisations. It is necessary, therefore, on this important ground as well as others already mentioned that the sanitarians of the United Kingdom should forthwith set their rural sanitary house in order.

### Notes on Current Topics.

#### Complimentary Dinner to Surgeon-General Jameson, C.B.

A COMPLIMENTARY dinner was given to Surgeon-General Jameson on Wednesday last, with Sir William Church, Bart., President of the Royal College of Physicians, in the chair, in the Grand Hall of the Hotel Cecil, at which upwards of 150 representative medical men assisted. The Chairman, in proposing the toast of "Our Guest" reviewed this distinguished officer's career from the days when he took part in repelling the Fenian raiders in Canada to his appointment to the post of Director-General of the Army Medical Department in 1896, a post which he had held during a very eventful and trying period, in respect of which every credit was due to him and to his department. Surgeon-General Jameson, in replying to the toast, dwelt upon the difficulties with which he had to contend during the strain of the war, and

pointed out that with regard to supply the medical department was only responsible for medicine and medical and surgical appliances, food and so-called medical comforts being supplied on requisition to the Army Service Corps. Consequently the blame, if any, should be apportioned to those on whom it properly fell. With respect to ambulance arrangements, he pointed out that the post of medical officer had been abolished against the advice of the medical department. Then, again, the selection of sites for hospitals in camps was the duty of the Royal Engineers or of the barrack department, but as a matter of fact the medical department had had to undertake the adaptation of buildings at a time when their hands were full of their own work. A large increase of medical transport was indispensable in future if war was to be carried out on humanitarian principles. Lastly, he remarked that the Director-General was not a member of the War Office Council or of the Army Board, so that matters concerning his department were discussed in his absence, only coming to his knowledge after considerable delay. Sir William McCormac, in proposing the toast of "The Public Medical Services," expressed regret at the fact that there was not at present a single candidate applying for admission to the Services. He thought the Army Medical Department had done its work extremely well under circumstances of considerable difficulty. They had received blame which belonged to other departments, and it was strange, he observed, that the Government had allowed Surgeon-General Jameson to leave the Army without the customary recognition given to every one of his predecessors and without one word of thanks or acknowledgment. The speeches were listened to with great attention, and as an expression of admiration and respect for the late Director-General the dinner was eminently successful.

#### Nasal Reformation.

At a recent meeting of the medical board of the Massachusetts General Hospital Dr. J. P. Clark showed a patient who had applied to him for relief in respect of a nose which sinned against her æsthetic soul in the direction of too pronounced a Roman outline. The prominent angle which characterises this variety of nasal appendage is due to the projection forward of that part of the septum, and, as shown by Dr. Goodale, this can be remedied without tampering with the skin. Dr. Clark followed his procedure, which consists in passing a pair of short curved scissors into the left nostril, one blade being made to perforate the septum just below the lower end of the prominence. Then, with the convexity of the scissors upwards, he frees the septum opposite the prominent part of the nose, following as closely as possible the contour of the nose. He next snips off the projecting piece of septum by the aid of a pair of straight scissors, and saws through the nasal bone as nearly as possible at its junction with the nasal process of the superior

maxillary bone, care being taken not to injure the skin. The process is repeated on the other nasal bone, and then a few taps on the external projection is sufficient to break down the frontal articulation. The bones can then be depressed into contact with the revised septum, and the deformity, if it is to be regarded as such, subsides. The result, judging from the photographs shown, was very satisfactory. It may be that in operations of this kind surgeons may find the means of occupying their time during the dead season if only the public can be induced to take enough interest in their personal appearance to consent to their too prominent contours being rounded off. Hitherto surgeons in this country have limited their efforts to the restoration of noses which have been eaten or blown away, and in rare instances to the ablation of redundancies of fibrous tissue in the subjects of chronic alcoholism. Purely cosmetic operations offer a much wider scope, but, so far, ladies display marked reluctance to modify the features bequeathed to them by undiscriminating sires.

#### Death from Cocaine Poisoning.

AN inquest was held last week at Cromer on the body of a young married woman who had succumbed to the effects of cocaine injected in view of a dental extraction. The assistant, an unqualified man, made three injections, equivalent to one grain of the alkaloid, and shortly after the teeth had been extracted convulsions set in, and death supervened within an hour without consciousness having been regained. It is remarkable that death should have resulted from this comparatively small quantity. According to Dr. Murrell recovery has followed the injection of as much as fourteen grains, though anything over half a grain may give rise to very unpleasant symptoms of cardiac oppression. The most unsatisfactory feature of the case is the administration of the drug by an unqualified assistant, who ran some risk of being committed for manslaughter, but the jury tempered justice with mercy by describing it as an accidental occurrence.

#### Army Hospital Accommodation in London.

DAY by day the public attention is being called to some fresh flaw in the administration of the Army Medical Department. During the past week the *Daily News* has made a fierce frontal attack upon the army hospital accommodation for the metropolis. It seems that scarlet fever has broken out among the men of the 1st Life Guards, now stationed at Knightsbridge barracks. The significance of the outbreak lies chiefly in the fact that the construction of the barracks in question is bad from a sanitary point of view, and that the building is overcrowded. There is no special army fever isolation hospital, so that the fever patients are sent to the public infectious hospitals, a proceeding which is, doubtless, most advantageous to themselves and to everyone else concerned. The fact that the barracks are not open to control

by the district local sanitary authority, however, constitutes a standing menace to the public safety. As a class, army medical officers are not, and probably never will be, sanitary experts. Why, then, should not the barracks be handed over to the district medical officer of health? It may safely be predicted that were public sanitary authorities entrusted with the supervision of military quarters the present system of housing would speedily be revolutionised. The Metropolitan Station Hospital in Rochester Row has been condemned over and over again by boards of inquiry, yet it still furnishes an object-lesson of military maladministration. The British Army, which is the most costly in the world, is provided with a wretched hospital that no civilian would tolerate for an hour. The problem before the reformer in army medical matters appears to be where to begin sweeping out the Augean stable.

#### The Government Tax on Quackery.

A WEEK or two since an enterprising tradesman was fined by the Rochdale magistrates for selling medicine in the market-place, first, without a stamp, and secondly without a license. It appears that the defendant vended some stuff called "Critchley's Indian Balm," whereby he professed to cure indigestion, at the extremely moderate price of sixpence a bottle. As to the merits of that particular preparation it is, of course, impossible to pronounce absolutely, but it may fairly be assumed that the "balm" was about as worthless as most of the cures for dyspepsia sold under cover of a quack label. Moreover, the varieties of dyspepsia are legion, and demand an infinite variety of skilful treatment, a fact that may be commended to those who pin their faith to ignorant charlatans with their "cures" for indigestion. The Rochdale prosecution, however, contains an even profounder moral. The proprietor of the balm in question, it appears, had a license to sell his precious stuff in Oldham but not in Rochdale, whence arose the police-court trouble. The position of a Government that issues a license for the sale of quack medicines is peculiar. In return for a paltry annual payment permission is granted to any quack to sell his worthless and fraudulent wares. If it be shown that such stuff is injurious to the health of His Majesty's lieges then the Government most clearly becomes accessory to a felonious act. This view of the matter may be commended to *Truth*, the only lay journal with the courage of its opinions in dealing with quack medicine vendors.

AN adjourned meeting of a number of members of the profession practising obstetrics and gynaecology was held in London on July 24th, under the presidency of Sir John Williams, at which it was unanimously resolved to establish a new journal, to be called *The British and Colonial Journal of Obstetrics and Gynaecology*, and to raise the funds required for its publication by the formation of a limited liability company.

### A "Herbalist" Sentenced to Death.

THE recent sentence to death of a "herbalist" at Hartlepool for the wilful murder of a woman by illegal operation calls for some comment. The occupation of a "herbalist" is an anomalous one, and there can be no doubt that the title is in many cases simply a cloak for nefarious practices. That the man who carries on that kind of business is often an abortionist is notorious. It would be well, therefore, for the police to keep a tight rein on all "herbalists." There are many ways in which such men might be brought to book, in spite of the deficiencies of the Medical Acts. A few well-directed prosecutions might drive away this sort of charlatan from a town before he committed the more serious offence of procuring abortion. The herbalist trade, however, at its best must be a wretched fraudulent kind of quack medical practice, and as such should be suppressed by law. What we really want is a bracing up of the Medical Acts, so that all unqualified practice could be promptly and efficiently suppressed. The present Acts are rendered inoperative for the most part simply because an offender to become liable must style himself a medical man. The simple amendment of that particular would strike a death-blow to an enormous amount of quackery now practised at the cost of life and health to the nation.

### Death from Fright (?)

ANY departure from the stereotyped formula of "weak heart" as an explanation of death under chloroform is welcome, but we question the possibility of diagnosing death from fright while under chloroform from death due to asphyxia, the usual cause of death in fatal cases of chloroform narcosis. At an inquest held a few days since at Stockport, on the body of a man who had died "before he had inhaled it in any great quantity," the convulsions were attributed to fright, and this view was endorsed by the jury. It would have been more to the point if the jury had inquired how much chloroform had been administered, by what means, and with what precautions, though in all probability they would not have been any wiser for their trouble.

### British Medical Association.

THE sixty-ninth annual meeting of the British Medical Association was opened at Cheltenham yesterday (Tuesday), under the presidency of Dr. George Bagot Ferguson, who delivered his presidential address last evening at the Princess Hall of the Ladies' College. The meeting was preceded by a special service at 11.30 o'clock at St. Matthew's Church, when the sermon was preached by the Dean of Gloucester. To-day (Wednesday) Dr. James Frederick Goodhart, F.R.C.P., is to give an address in medicine at 8 p.m. in the Princess Hall. On Thursday Sir William Thomson, C.B., M.D., Honorary Surgeon to the King in Ireland, will give an address in surgery at 2.30 p.m., after which the Stewart Prize will be presented to Dr. Patrick

Manson, F.R.S., for his researches in the pathology of tropical diseases, especially in regard to the malaria of man and to the life-history of the malarial parasite both in man and in the mosquito, and in recognition also of the stimulating influence which he has exerted for many years on the study of tropical diseases in the British Empire. The scientific work of the meeting is being conducted in thirteen sections. The first general meeting of members was held in the Princess Hall of the Ladies' College on Tuesday at 2.30 p.m., when the report of Council and the reports of committees were considered.

### The Privacy of Medical Examinations.

IT has been more or less the custom at medical examinations under the Workmen's Compensation Act for the solicitors of the parties to be present, a practice which presents obvious inconveniences, but one against which it was difficult to effectually protest. Thanks to the action of Judge Addison, of the Southwark County Court, an official pronouncement has been obtained, which will serve as a guide in future. In a case recently before him, in which the medical evidence was contradictory, the matter was referred to the Home Office referee. The solicitors wished to be present at the examination, and permission having been refused a request was made for a copy of the referee's report. This the judge also refused, and applied to the Home Office for an opinion on his ruling. We are pleased to learn that his Honour's ruling has met with the cordial approval of the Home Office, and it is now laid down that medical examinations are to be made privately, and that the referee's report, being primarily for the guidance of the Judge, is of the nature of a confidential document, though he can communicate it at his discretion. Apart from the economy of law costs which will result from this decision, it is obviously desirable that medical examiners should not be hampered by the presence of lawyers whose interference could only have for effect to add to the difficulty of making the inspection thorough, searching, and impartial.

### Plague at the Cape.

IT may be doubted whether we at home have ever properly estimated the danger of the plague at the Cape. A rigorous press censorship kept back the news of the arrival of the malady weeks after it had been announced in the Continental journals. In spite of official repression, however, information has leaked out of cases of plague in various places up country. We cannot help thinking that a policy of candour would be better calculated to maintain the confidence of the public. There has recently been a marked remission in the amount of disease at Cape Town, but that the scourge is still potent for mischief is shown by the fact that three fresh cases were notified in the last week under official report. From the beginning of the epidemic to the end of the period mentioned there have been altogether 772 cases of plague and 368 deaths

Anyone conversant with the conditions of plague must at once recognise the menace contained in that statement. The total volume of specific infection thus involved is enormous, especially in a country with such imperfect sanitary administration as the Cape. It is to be hoped that the authorities at the War Office will not allow themselves to be lulled into a false sense of security by the apparent diminution of the numbers attacked by the malady.

#### The Inwardness of the Horses' Sun-bonnet.

SOME years ago the attention of the medical profession was first drawn to the straw hats used for the purpose of protecting the heads of horses from the sun. Since that time the fashion has not only grown in popular favour but has further blossomed out into a crop of eccentric and fantastic vagaries. The original headgear made out of a plain peaked straw hat, with holes cut for the ears, has developed into hats of manifold pattern decorated with ribbons and artificial flowers, and in variously shaped contrivances slung in the air at angles more or less calculated to protect the cranium of the noble animal beneath. All this ingenuity is a good sign of the humanity that underlies the outer shell of mankind. The horse may be mercilessly whipped, or under-fed, or overworked, or tied up with bearing-reins, but at any rate here is an opportunity for showing that we do not altogether neglect his bodily comfort. As to any beneficial effect to be derived from the equine sun-bonnet it is open to question whether any additional safety is thereby conferred upon the long-suffering animal concerned. Science has shown that sunstroke is not due to heat but rather to micro-organisms. The part played by hot weather consists in providing the conditions necessary for the development of the "sunstroke" organisms. All the same it is advisable to protect the skull from the rays of the hot sun, whether tropical or otherwise, and on that ground the use of the sun-bonnet for horses may be consistently upheld. One word of caution may perhaps be added. The openings in the headgear should be so made that there is not the least friction or pressure upon the ears. Those most sensitive organs are in constant motion, and anything that restricts their free movement must prove a source of never-ending irritation to a horse, to say nothing of the actual galling that may ensue. If this fashion is not to rank among the most foolish of modern freaks it should be followed with some regard to the dictates of common sense and to the laws of physiology. In other words, it should not be allowed to become a completely feminine fashion.

#### The Interpreters of Professor Koch.

AT the combined meeting of Sections 2 and 3 of the Congress on Tuberculosis, held at the Royal Medical and Chirurgical Society, on July 24th, much diversity of opinion was expressed on the value or otherwise of the use of tuberculin. Dr. Heron gave his results, and Dr. Theodore Williams, in recounting his experience, was in direct opposition, both as

to fact and theory, to Dr. Heron. Dr. Heron's views were practically those of Professor Koch, and when the latter replied, at the end of the discussion, in the German language there was a very loudly expressed wish that his views should be then and there expounded in English to the meeting. Whether it was difficult to follow Professor Koch, or whether the gentlemen who attempted to convey his meaning to the section failed to comprehend his argument, it is difficult to decide; but it was amusing for the section, though disconcerting to the interpreters, to see Professor Koch shake his head at the various attempts made to explain his views. There was no lack of volunteers to enlighten the meeting as to what they thought Professor Koch meant, but as time was precious and the translators did not seem to find favour as regards accuracy in the eyes of Professor Koch, the chairman brought the amusing incident to a close. The amateur interpreters must be credited with firm belief in their ability to correctly translate the views of Professor Koch, for the members present indulged in remarks which were painful and frequent and free, and by no means uttered in low tones, on the respective merits of the different performers. The sections sat from half-past nine to half-past one, and the unofficial entertainment provided was much appreciated.

#### Expectation and Expectoration.

THE ceremony of inaugurating the British Congress on Tuberculosis was naturally a very serious and dignified affair, and the wonderful patience of the number of ladies who sat the decorous function right through is much to be admired. St. James's Hall, in which the ceremony of opening the Congress took place, became, on account of the weather, terribly hot, and by the end of the function many of the audience were observed to be quietly slumbering. Those who were able to keep awake were rewarded with one amusing incident; a most worthy and distinguished foreigner, of great scientific repute, was addressing the audience in English, and he spoke remarkably well, but in his excitement in delivering his peroration he expressed the hope that the Congress would come up to their expectation. Quick though he was to correct himself his audience had recognised the humour of the verbal slip, and the roar of laughter prevented the speaker from continuing his discourse for some little time.

#### Vegetarianism and Phthisis.

LORD DERBY must be congratulated on the marvellous tact with which he was able to deal with unexpected interruptions in the course of the conduct of the business of large public meetings. He presided at the final meeting of the British Congress on Tuberculosis on July 26th, and was skilfully securing the successful acceptance by the assembly of the very wordy and non-committal series of amendments which were laid before the members and delegates, when suddenly he found himself addressed by a lady whose name was understood to be Mademoiselle Vergelle, and who spoke clearly and to the point.

She addressed the meeting because, in her opinion, a great deal could be done towards stamping out tuberculosis if the medical profession were to pay greater attention to the value of prescribing a vegetable diet. Lord Derby listened with the utmost courtesy to all that the advocate of Vegetarianism had to say, and having waited for a short time to see if anyone wished to continue the theme, he pleased the audience by passing on at once to the business of the meeting, and thus succeeded in preventing any waste of time without subjecting the courageous lady to any feeling of mortification. The meeting is to be congratulated on having secured such a tactful chairman, and Lord Derby complimented on his gallantry.

#### The Liability of Sanitary Officers.

ONE of the verbose resolutions passed at the final meeting of the Congress on Tuberculosis was to the effect that sanitary officers should be encouraged in their efforts to prevent the increase of tuberculosis. Some gentleman whose name did not transpire, speaking from the midst of the crowded audience, very pertinently suggested that the meeting should pass an expression of opinion that the sanitary officers should be freed from their present liability in respect to their efforts to prevent the sale of tuberculous milk. The speaker was greeted with loud cries of dissent, which he very successfully met by showing the necessity of doing what he advised, and gave as an example the fact that a Sanitary Officer at Warwick had been subjected to legal proceedings for slander because he had done his duty in his official capacity for the protection of the public. Perhaps the fact that the meeting was detained from attending a popular water-picnic at Richmond may have accounted for the cold welcome accorded to the very reasonable proposal. The matter, however, is of some importance, and must not be allowed to drop.

#### The Plague.

THE reappearance of the plague in Honolulu in spite of the very comprehensive precautions taken against the epidemic is, to say the least of it, embarrassing, but the obstinacy with which the infection continues to make itself manifest in Cape Town, not only among the coloured races, but equally so among the whites, together with the reports concerning the seventh recrudescence of the plague in Hong Kong, renders a consideration of the present outlook a far from cheerful one. There is not much consolation in the information that when once a town has been infected recurrences must be expected, and the worst of it is, judging from Hong Kong, the attacks by no means seem to decrease in virulence as they increase in number. As far as can be judged from the facts to hand, this last outbreak in Hong Kong threatens to be the most serious calamity that that district has as yet suffered. For anyone to accept as proved the assertion that modern scientific methods are perfectly able to cope with plague requires either very robust faith or a large measure of obstinate prejudice.

#### Excessive Cough in Phthisis.

THE treatment of excessive cough in a tuberculous patient requires much judgment. A certain amount of cough is undoubtedly in a large number of cases indispensable and has a salutary influence. The treatment of this symptom was discussed by Dr. Huggard, of Davos Platz, before the Congress on Tuberculosis, and as he very well put it, the problem is to secure the removal of the pulmonary and bronchial secretion with the least amount of violent exertion or fatigue to the patient. The difficulty is that sometimes the secretions are very abundant and sometimes too scanty. The balsams and the terebinthines diminish secretion and apomorphine in small doses loosens the secretions. The recently introduced morphine derivatives, heroin and dionin diminish cough and expectoration, are devoid of constipating effects, and do not disturb the digestion. The indication appears to be that Dr. Huggard's views are in accord with others, and in a clinical lecture lately delivered at St. Bartholomew's Hospital Sir Lauder Brunton mentioned heroin as a useful therapeutic agent for cough, under the circumstances described.

#### The Diagnosis of Tuberculosis.

A MEANS of diagnosis in pulmonary tuberculosis is found in the attentive study by means of the radioscope of the function of the diaphragm and inspiratory muscles. If one examines a patient apparently in a good state of health, or simply affected by weakness, and the movements of the lungs are studied together with the degree of clearness of the lungs, and especially the action of the diaphragm, a diagnosis may be arrived at in the pre-tuberculous period. The opinion is formed by noticing anomalies in the synchronism and amplitude of movement of the two halves of the diaphragm in their rise and fall or in their curvature, and it is possible, in the absence of any other sign, to give a diagnosis of a predisposition to, or commencement of, tuberculosis, unless an evident cause for these anomalies can be discovered. This subject has been exhaustively treated by Dr. Bonnet Leon, of Paris, and he has communicated his views to the British Congress on Tuberculosis.

#### The Next International Congress of Medicine.

THE fourteenth International Congress of Medicine will be held at Madrid from the 23rd to the 30th April, 1903, under the patronage of King Alphonso XIII. and the Queen Regent. The subscription is thirty pesetas (equivalent to twenty-four shillings). Ladies accompanying members will be able to obtain the privileges of members, i.e., reductions on the Spanish railways, &c., on payment of twelve pesetas, or ten shillings apiece. The National Committee for Great Britain and Ireland remains the same as at the Paris Congress, Sir William MacCormac, Bart., K.C.B., K.C.V.O., being the President. The honorary secretaries are Dr. Percival Horton-Smith, of 15 Upper Brook Street,

Grosvenor Square, W., and Mr. D'Arcy Power, F.R.C.S.Eng., of 10A Chandos Street, Cavendish Square, London, W.

#### Compensation for Condemned Meat.

THE members of the Veterinary Section of the Congress on Tuberculosis were very much in evidence at the fifth general meeting of the Congress. Every seat in the Queen's Hall, where the meeting was held, had placed upon it a copy of the resolutions submitted to the Veterinary Section in regard to the confiscation and destruction of condemned meat. Mr. J. Bowen Jones tried without avail to persuade the Chairman to allow these resolutions to be submitted to the meeting, but Lord Derby said he was unable to do so because they contained so much matter of an argumentative nature. Mr. Bowen Jones was assured that the resolutions would be considered by the proper authorities, and like a wise man, seeing it was hopeless to press the matter further at that moment, he acquiesced in the inevitable.

#### The Sale of Cocaine.

THE suicide of two young women in London by taking cocaine has served the useful purpose of directing public attention to the ease with which comparatively large quantities of this highly poisonous drug can be obtained. There is reason to fear that the practice of using the alkaloid as an intoxicant is on the increase. In reply to a question in Parliament by Mr. Macdonald, it was stated that a committee of the Privy Council has been appointed to consider the first schedule of the Poisons Act (1868), and that the expediency of placing cocaine in that list will be referred to it.

#### Liability for Domestic Servants.

IN an action brought by Dr. Williams, of North Walsham, Norfolk, against a servant for medical attendance the claim was opposed on the ground that the girl's master had sent for the doctor, and not the patient herself, and on that ground the judge gave judgment for the defendant. The jurisprudence in such matters is now pretty well established, and it would be well in every instance for the practitioner who has been called to a servant to have a clear understanding as to who is going to be responsible for the fees.

WE are requested to call the attention of those of our readers who purpose availing themselves of the "tour of instruction" organised by Dr. Carron de la Carrière through the watering-places of Southern France, to the fact that all applications must reach him at his address, No. 2, Rue Lincoln, Paris, before August 15th. No more favourable opportunity could be offered for visiting these picturesque sites and of becoming acquainted with the therapeutical value of their springs. The cost of the round trip, including travelling and hotel expenses, carriage journeys, &c., is 300 francs (£12).

AN inquest was held on the 22nd inst., at Birmingham, on the body of a man who had succumbed to chronic brass dust poisoning, and the coroner intimated his intention of representing to the Home Office the desirability of instituting an inquiry into the subject. We have no knowledge of specific intoxication as the result of inhaling brass dust, and it is probable that the deleterious effects with which it is credited are in reality due to the irritating effects of the dust, as such, on the air passages.

Two patients supposed to be suffering from plague were landed last week at Plymouth from the Orient liner *Ormuz*, and a number of passengers were vaccinated as a precautionary measure, all the crew having undergone this prophylactic measure during the voyage. Bacteriological examination, however, did not confirm the suspicions, and all restrictions have now been removed.

THE death is announced of Dr. Edward S. Morley, J.P., of Blackburn, at the age of 70. Dr. Morley in his younger days was an enthusiastic athlete, and took an active part in the local organisations having in view the development of the various sports, but he was also a much esteemed physician, and his death has excited widespread regret.

#### PERSONAL.

DR. E. J. MACLEAN has been appointed Gynæcologist to the Cardiff Infirmary out of six candidates.

DR. JOHN JONES, who recently returned from South Africa, has been appointed Medical Officer to the Mond Nickel Works, Clydach.

MR. R. WHITESIDE STATHAM, M.R.C.S., has been appointed Deputy-Coroner for North Somerset, *vice* Dr. J. Wallace, who has resigned.

THE Fellowship of the Royal College of Physicians, London, was bestowed on Dr. W. J. Tyson, of Folkestone, whose Membership is dated 1889.

IT appears that Dr. Isambard Owen has not seen his way to accept the offer of the post of Principal of the Cardiff University College which was offered to him.

MISS AGNES REYMNER SINCLAIR, M.B., Ch.B. Glasg., of Clarenceville, Longsight, Manchester, has been appointed Resident Medical Officer to the Carlisle Dispensary.

THE Colonial Office has notified that Dr. E. Bowmaker, of Sunderland (an old subscriber and contributor to this journal), who was in the Ashantee Expeditionary Force, died of malarial fever on July 6th at Parmu, Gold Coast Interior.

PROFESSOR ROBERT KOCH was entertained at dinner on Wednesday evening last at the Hôtel Métropole by the Royal Institute of Public Health, when he was presented with the Harben Gold Medal for 1900 and the Honorary Fellowship of the Institution.

THE "Baly Gold Medal," which is presented every alternate year by the Royal College of Physicians of London for special distinction in the science of physio-

logy, has been this year awarded to Dr. F. W. Pavy, F.R.C.P., F.R.S., consulting physician to Guy's Hospital.

THE Council of King's College, London, have elected Dr. R. Tanner Hewlett, of the Jenner Institute of Preventive Medicine, to the Professorship of General Pathology and Bacteriology; and Dr. St. Clair Thomson to be Assistant Physician for Diseases of the Throat.

DR. A. DAVIDSON, late Senior Assistant Medical Officer at the Dorset County Asylum, on his resigning that appointment to enter the Colonial Medical Service, has been presented by the medical officers and staff with a valuable tea service in silver in recognition of his "zealous work and kind attention."

DR. NORMAN MOORE has been selected by the Royal College of Physicians, London, to deliver the Harveian oration on St. Luke's Day, October 18th, and Dr. Judson Bury the Bradshaw Lecture in November. Dr. G. F. Still has been appointed Goulstonian Lecturer, Dr. F. T. Roberts Lumleian Lecturer for 1902, and Dr. C. E. Beevor Croonian Lecturer for 1903, to the same college.

DR. S. WEIR MITCHELL, it is announced, has just returned to the States from a trip around the world. Evidently the doctor has the reputation of being a worker, for a newspaper asserts that six long novels, forty-nine sonnets, 103 quatrains and several other poems, not to mention four books of sketches, a treatise on nervous diseases, fifteen or twenty short stories, were dashed off by him at odd moments during his trip. All these precious works, we are informed, are now in the possession of Richard Watson Gilder, who has hired eight detectives to watch the stuff.

### Correspondence.

[We do not hold ourselves responsible for the opinions of our correspondents.]

#### THE PROPOSED NEW JOURNAL OF OBSTETRICS AND GYNÆCOLOGY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In one of your "Leading Articles" in to-day's issue you draw attention to a proposal to start another *Journal of Obstetrics and Gynecology*, and as there is no advertisement or public announcement of the meeting to be held to-day, I suppose it is more or less of a private concern. Now we have had some experience of a similar effort in *The Obstetrical Journal*, which ran for eight years (1873-1800) and then expired. Nearly all the gynæcological societies in this country issue Proceedings or Transactions, in the main limited to reports of their own work, but we have already the experience of a journal, *The British Gynecological Journal*, which covers exactly the ground that is proposed to be included in the new journal, and has been in existence sixteen years. This journal is not only British, but it is cosmopolitan, and contains not only the Transactions of the British Gynecological Society, but also reports of the various gynæcological societies of the Empire, together with material from foreign countries. I do not see, therefore, where is the need or room for another journal on identical lines, nor what prospect it has of a great success, inasmuch as no private issue is likely to carry the weight or prestige that attaches to a society that has done such good work, or has so world-wide a reputation as the British Gynecological Society. Any new journal on these lines will be run mainly in opposition to the *British Gynecological Journal*, and it will require to be some-

thing especially good to have much chance of success against a journal that has run into sixteen volumes. Perhaps one devoted exclusively to obstetrics might do better.

I am, Sir, yours truly,  
HETWOOD SMITH.

Harley Street, W., July 24th, 1901.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Though there are many points raised in your leader referring to the proposed journal, there is but one that I desire through your columns to comment upon. Most emphatically the proposed journal will not be representative "of the entire obstetrical and gynæcological world of Great Britain and Ireland." Already a large number of prominent obstetricians and gynæcologists, in the metropolis alone, feel that they have been deliberately excluded from all participation in the movement. A meeting, to which they were not invited, was summoned by invitation to consider the matter, and its proceedings were limited to a favoured few. Further, it is an open secret that this journal has been conceived and taken in hand mainly by those who are openly and avowedly hostile to the British Gynecological Society and its *Journal*. Whether under these circumstances the promoters of this one-sided undertaking will succeed in creating "a universal journal" is a point which time will prove. One thing is certain—that it never will be, in the truest sense, "representative of British obstetrics and gynæcology."

I am, Sir, yours truly,

A LONDON OBSTETRICIAN AND GYNÆCOLOGIST.

[We can only repeat what we have already said. In our opinion there is room for an "imperial" journal of obstetrics and gynæcology. The more truly imperial the new journal is, the less it will interfere with the interests of individual British societies. If, as our correspondents say, the meeting of last Wednesday was "more or less of a private concern," we fear it does not augur well for the future success of the proposed journal. Who is responsible for the assumed privacy? —Ed.]

#### UNDESIRABLE PROSECUTIONS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—With regard to your comments (*MEDICAL PRESS AND CIRCULAR*, July 24th) on the "abortive proceedings" against Dr. H. Whitmore instituted by the Medical Officer of Health for Camberwell, that gentleman no doubt according to his lights performed his duty, or at least what he thought such. It should be remembered, however, that the law has forced upon the medical profession the exceedingly delicate and difficult task of notification, hence very strong evidence indeed should be forthcoming ere the law is set into motion against any practitioner. Speaking generally of notification, medical officers of health may take it that the tendency nowadays is to notify precipitately; at least it is certain that innumerable doubtful cases are recorded and sent away at enormous public expense that would rapidly recover under the most simple treatment if the diagnosis were only delayed for a day or two, and this is proved by the fact that so many turn out futile.

I am, Sir, yours truly,

CLEMENT H. SEES.

130, Queen's Road, Peckham, S.E., July 24th, 1901.

#### FEMORAL CYSTOCELE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—As femoral cystocele is very uncommon, I copy the following from the *Am. Journal of Surgery and Gynecology*:—A woman with a lump protruding from the left femoral ring, exquisitely sensitive, the size of a small hen's egg, hard, and somewhat nodular, came under observation. There was no fluctuation, no impulse on coughing, no difference in size on the woman taking the upright position, no history of constipation, and no pain during the action of the bowels.

On the operation table the lump was exposed by dissecting up a small circular flap. The operator considered that he had to deal with an omental hernia, or, perhaps, an ovarian one. After removing the fatty tissue, together with the adhesions that had formed round the sac, it was evident that the mass did not contain an ovary, but resembled a thickened piece of omentum. A snip of the piece was made for microscopic examination, and the issue of some clear fluid told that a cyst of some sort had been opened, probably the urinary bladder. The diagnosis was confirmed by the passing of a sound through a very small incision. The instrument was distinctly felt in the bladder. The opening was sutured and the bladder returned to the abdominal cavity. The patient made a good recovery.

I am, Sir, yours truly,  
Dublin, July 27th. GEORGE FOX.

#### THE ANDERSON FUND.

THE Committee formed to appeal for aid on behalf of the widow and two sons of Mr. R. B. Anderson, F.R.C.S. (see MEDICAL PRESS AND CIRCULAR, July 10th, pp. 49-50), beg to gratefully announce the following list of subscriptions to July 26th, amounting in all to £52 10s. :-

	£	s.	d.
The Earl of Stamford (Chairman) ...	10	0	0
Timothy Holmes, Esq., F.R.C.S. (Hon. Treasurer) ...	5	0	0
H. E. Juler, Esq., F.R.C.S. ...	2	2	0
Dr. Higham Hill ...	1	1	0
Dr. Lorimer Hart ...	1	1	0
Dr. Alfred Cox ...	1	1	0
Dr. Wheeler O'Bryan ...	0	10	6
Dr. Milner Brown ...	0	10	6
Walter Monnington, Esq. (Hon. Sec.) ...	1	1	0
Lord Lister ...	10	0	0
Dr. Herbert Owen ...	1	1	0
Dr. Duka ...	1	1	0
Dr. W. Domett Stone ...	1	1	0
Dr. John Brown ...	0	10	0
A Friend ...	1	0	0
Thomas Smith, Esq. ...	5	0	0
Sir R. M. Craven ...	1	1	0
E. E. Llewellyn, Esq. ...	1	1	0
J. Granville Hockridge, Esq. ...	1	1	0
Dr. C. Crawford ...	1	1	0
J. H. Waddington, Esq. ...	0	10	6
W. Smith, Esq. ...	0	10	6
Dr. C. Coates ...	2	2	0
Dr. G. F. Blandford ...	3	3	0

Total ... £52 10 0

THE EARL OF STAMFORD, Chairman.  
TIMOTHY HOLMES, Esq., F.R.C.S.,  
Hon. Treasurer.

WALTER MONNINGTON, Esq., 7, Fig  
Tree Court, Temple, E.C., Hon. Sec.

Donations for "the late R. B. Anderson Fund" should be sent and made payable to *The Manager, Union Bank of London, Chancery Lane, London.*

#### NOMENCLATURE OF DIARRHOEAL DISEASES.

THE Registrar-General for Ireland has issued the following circular letter to the medical profession in Ireland:—

General Register Office,  
Charlemont House, Rutland Square,  
Dublin, July 19th, 1901.

GENTLEMEN,—I beg to bring under your notice the fact that the Diarrhoea Nomenclature Committee of the Royal College of Physicians, London, at their meeting held on November 20th, 1899, recommended the College to authorise the use of the term "epidemic enteritis" (or, if preferred by the practitioner, "zymotic enteritis") as a synonym for epidemic diarrhoea ("Nomenclature of Diseases," p. 9, ed. 1896) and further recommended the entire disuse as synonyms of epidemic diarrhoea, in medical certificates of death, of such terms as "gastro-enteritis," "muco-enteritis," or "gastric catarrh." This recommendation was submitted

to the Royal College of Physicians, London, and unanimously adopted at a meeting of the Fellows held on January 25th, 1900.

I had the honour of bringing the matter under the notice of the Royal College of Physicians, Ireland, who have endorsed the opinion of the London college. May I ask the favour of your kind co-operation in carrying out the views of the heads of the medical profession.

I am, Sir, yours truly,  
R. E. MATHESON, Registrar-General.

#### Obituary.

SURGEON-MAJOR FREDERICK ROBINSON,  
M.D., F.R.C.P.

THE death is announced of Dr. Robinson, at Eastbourne, an old and much respected member of the Army Medical Service (retired). He entered it in 1847 as assistant-surgeon in the 74th Foot, in which regiment he continued until his transfer to the Scots Fusilier Guards in 1852. He became battalion surgeon in the year 1857, and surgeon-major of the battalion in 1867. Dr. Robinson accompanied the Scots Fusilier Guards to the Crimea in 1854 as senior assistant-surgeon, and served uninterruptedly with the battalion until the termination of the war. During a great part of the time he was in medical charge of the battalion. He was present at the Battles of the Alma, Balaclava, and Inkerman, and at the siege and fall of Sevastopol, and the sortie of October 26th, and had the British medal with all the clasps for these engagements, in addition to the Medjidieh and Turkish medals. For distinguished conduct in the field at the Battle of the Alma he was recommended for the Victoria Cross by Colonel Walker and was personally complimented for his conduct during the campaign, on the field at Inkerman by Lord Raglan and by the Duke of Cambridge after the Battle of the Alma.

MR. J. A. RIGGE, M.R.C.S., L.R.C.P., OF HENLEY.

THE deceased, who had been in failing health for some time past, died of pneumonia a few days ago at the early age of 41. He was held in very high esteem by all classes in the town and neighbourhood, and his death is much deplored. He was an enthusiastic Volunteer, and also served on the Town Council for three years. He had been for some years the medical officer of the Henley Workhouse, and was also connected with the Hearts of Oak Benefit Society, and his kindness and courtesy made him a very popular officer. The funeral took place at Bix churchyard on Wednesday afternoon, amid every token of respect.

#### Medical News.

##### Medical Gold Medallists.

THE results of the July Intermediate Examination in Medicine at the University of London were published on the 23rd inst., and the following are the students to whom medals have been awarded:—

For Anatomy: Ernest Edgar Maples, St. Bartholomew's (gold medal), and William Gordon Taylor, Middlesex (medal and exhibition). Seymour Gilbert Barling, Birmingham University, is marked "deserving of medal."

For Physiology and Histology: George Hall, University College (medal and exhibition), and Thomas de Smith (Cambridge University and London Hospital (gold medal)).

For Materia Medica and Pharmaceutical Chemistry: Arthur Campbell Stark, Westminster (medal and exhibition).

##### The Dublin Death Rate.

It is with unfeigned pleasure that we note a fall in the Dublin death-rate, which is a shade under 20 deaths per 1,000. Indeed, the present weather seems to have generally lowered the death-rate throughout Europe and America, the rates being: London, 16½ per 1,000; Glasgow, 18½; Paris, 17½; Amsterdam, 11½; Berlin, 16½; New York, 17½; Venice, 11½; Dublin,



1902. Thirty-seven of the persons whose deaths were registered during the week were under five years of age, twenty-four being infants under one year, of whom five were under one month old. It would be interesting to know how many of these little ones were nursed children, and how many were insured.

#### Royal Appointments.

Messrs. CANTRELL and COCHRANE ask us to announce that they have been honoured by the appointment under special warrant of purveyors of mineral waters to His Majesty the King. The waters supplied by these manufacturers are so universally known and appreciated that they have gained as many as thirty-two gold and prize medals. We recently put two or three of these waters under laboratory tests, and found they responded to the most searching investigation for purity.

#### Royal College of Physicians, London.

At the quarterly *comitia* of the College on Thursday last the following Fellows were elected officers of the College for the ensuing year:—Censors, Thomas Tillyer Whipham, M.D., Sir Dyce Duckworth, LL.D., M.D., Thomas Henry Green, M.D., George Vivian Poore, M.D.; treasurer, Sir Dyce Duckworth, M.D.; Emeritus registrar, Sir Henry Pitman, M.D.; registrar, Edward Liveing, M.D.; Harveian librarian, Joseph Frank Payne, M.D.; library committee, Samuel Gee, M.D., J. Wickham Legg, M.D., Norman Moore, M.D., William Henry Allohin, M.D.; curators of the museum, W. Howship Dickinson, M.D., H. Charlton Bastian, M.D., William Cayley, M.D., John Abercrombie, M.D.; finance committee, T. Tillyer Whipham, M.D., A. Lewis Galabin, M.D., and Stephen Mackenzie, M.D. The examiners for the ensuing collegiate year were elected at the same meeting.

The following candidates having passed the required examination, were admitted members of the college:—Thomas Bushby, M.B.Edin., Univ. Coll., Liverpool; Arthur H. W. Clemow, M.D.Edin., Univ. Coll., Liverpool, and Leipzig; John C. M. Given, M.D.Lond., Liverpool Royal Infirmary, Univ. Coll., London, and Vienna; Thomas W. Griffith, M.D.Aberdeen; Arthur D. Heath, M.D.Lond., L.R.C.P., and M.R.C.S., Univ. Coll., London; Thomas McCrae, M.B.Toronto, L.R.C.P., and M.R.C.S., Toronto and Göttingen; Frederick C. Moore, M.D.Vict., Owens Coll., Manchester; Harold D. Singer, M.D.Lond., L.R.C.P., and M.R.C.S., St. Thomas's.

#### The College of Preceptors.

ACCORDING to the report just issued the number of candidates for the professional preliminary examination in March last was 172, a marked increase on the figure for the previous year.

#### Leprosy in Russia.

THE measures taken to stamp out leprosy in Russia have not, so far, been attended by much success. In Lithuania, for instance, there are 609 cases under medical supervision, and there are 201 in Courland, 124 in Astrachan and 121 in the Kuban district. Last year a marked increase is stated to have taken place in the Caucasus, Central Asia, and East Siberia. In addition to the official cases there is every reason to apprehend that the disease exists in many other districts, and steps are being taken to investigate its prevalence.

#### Small-pox at Child's Hill.

THERE have been ten cases of small-pox in all at Child's Hill, the disease having been imported from Port Said. The sufferers were promptly isolated in an open-air camp, and the outbreak is now believed to be at an end, although a number of suspects are still under observation.

#### Metropolitan Asylums' Board.

DURING 1900 the numbers of patients suffering from fever, diphtheria, small-pox, and "other diseases," admitted into the hospitals of the Board were as follows:—Scarlet fever, 10,343; diphtheria, 7,873; enteric fever, 1,728; typhus, 4; small-pox, 66; and other diseases (exclusive of the non-small-pox cases detained at South Wharf or sent home at once), 1,707. The mortality per cent. was as follows:—Scarlet fever, 2.97; diphtheria, 12.27; enteric fever, 14.09; typhus, 22.23; small-pox, 4.35; and other diseases (exclusive of the

non-small-pox cases), 9.90. The bulk of the 66 cases of small-pox owed their infection to persons who themselves had contracted the disease abroad or in the provinces, and were taken ill soon after their arrival in London. During the financial year ended at Michaelmas, 1900, the managers spent £832,466, an increase of £65,682 over the preceding year.

#### Typhoid in South Africa.

IN reply to a question by Sir Walter Foster, M.P., it was stated that from returns received since June 25th the deaths for the four weeks ending April 26th are now given as 194. For the five weeks ending May 31st the admissions were 2,300 and the deaths 326.

#### More Officers for Volunteer Medical Staff Corps.

IT has been decided, in order that each Division or Company of the Volunteer Medical Staff Corps may have on its establishment a sufficient number of officers to supply the full quota on mobilisation, that additional Lieutenants shall be appointed, and officers so appointed will be granted outfit allowance.

## Pass Lists.

#### Royal College of Physicians and Royal College of Surgeons Ireland.

THE following candidates have passed the Second Professional Examination:—

(a) In all subjects.—J. Grace.  
(b) Completed examination.—P. Donnellon, A. H. B. Duncan, H. B. Evans, D. Gillies, B. D. Gibson, M. Hurley, L. F. Kelly, T. Keogh, A. C. Lewis, F. J. Moore, J. O'Doherty, J. P. O'Donnell, D. J. O'C. Kelly, P. P. Ryan.

The following have passed the Second Professional and Third Professional Examinations:—

#### SECOND PROFESSIONAL, PART II.

(a) All subjects.—Honours: M. J. Ryan. Pass: C. P. O'B. Butler, E. G. Griffin, L. B. Hanbury, Jas. Hayes, R. A. Murphy, L. P. Stokes.  
(b) Completed examination.—H. E. F. Hastings, J. R. H. Macmanus, V. H. MacSwiney.

#### THIRD PROFESSIONAL.

(a) All subjects.—Miss L. N. Alexander, J. E. Brereton, A. Charles, T. A. Dillon, Jas. Dwyer, C. Foley, Miss H. A. Hall, W. B. A. Moore, C. E. O'Keefe, P. W. Power, C. Waters.  
(b) Completed examination.—Miss M. E. Bridgford, S. Brown, J. Cuffe, Miss H. A. Driver, G. Lacy, J. J. McInerney, S. B. M'Cauleland, O. F. M. Ormsby, W. Scott, G. J. Sexton, S. A. Tucker, G. B. Wilkinson.

The following candidates have passed the final examination:—

(a) All subjects:  
1. Honours in order of Merit: P. I. Hanafin, Edmund Glenny, Miss M. J. Shire, A. H. B. Hartford.  
2. Pass; alphabetically.—H. L. A. Barry, J. P. Byrne, F. J. Cahill, M. J. Johnston, J. F. L. Keegan, I. M. S. Lewis, J. Loughrey, D. J. O'Reilly, John White.  
(b) Completed the Examination.—A. J. Connolly, P. L. Crosbie, C. H. Felvey, J. S. Lane, M. E. Lynch, R. F. MacMahon.

#### University of Aberdeen.

At the Graduation Ceremony on Wednesday last, July 24th, the following Degrees in Medicine were conferred:—

#### DEGREE OF DOCTOR OF MEDICINE (M.D.).

John Baker, M.B., C.M.; William John Byres, M.A., M.B., C.M.; Clarence I. Ellis, M.B., C.M.; Douglas Vercoe Haig, M.B., C.M.; James Selkirk Laing, M.B., C.M.; Harry Oliphant Nicholson, M.B., C.M. (New Regulations); James Porter, M.A., M.B., C.M., B.N.; James Wallace, M.A., M.B., C.M.

The Thesis of Mr. H. O. Nicholson was awarded "Highest Honours," the Thesis of Mr. J. S. Laing was awarded "Honours," and the Theses of Messrs. John Baker and Douglas V. Haig were awarded "Commendation."

The Lord Rector's prize for the best Thesis for M.D. of the year has been awarded to Mr. H. O. Nicholson.

## Notices to Correspondents, Short Letters, &c.

**✉ CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

**REPRINTS.**—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the publisher or printer before the type has been distributed. This should be done when returning corrected proofs.

**ORIGINAL ARTICLES** or **LETTERS** intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

**READING CASES.**—Cloth board cases, gilt lettered, containing twenty-six strings for holding the numbers of **THE MEDICAL PRESS AND CIRCULAR**, may now be had at the office of this journal, price 2s. 6d. These cases will be found very useful to keep each weekly number intact, clean, and flat after it has passed through the post.

### KNOWLEDGE AND WISDOM.

**THE** keen comment of Tennyson's when he said, "Knowledge comes, but wisdom lingers," indicates the difference between the two, a difference never better expressed than in the well-known lines of Cowper:

"Knowledge and wisdom, far from being one,  
Have oftentimes no connection. Knowledge dwells  
In heads replete with thoughts of other men;  
Wisdom in minds attentive to their own.  
Knowledge is proud that he has learned so much;  
Wisdom is humble that he knows no more."

In a recent number of the *Journal of the American Medical Association* the first item in the index is as follows: "Poverty and Pregnancy: Their Cause, Prevention and Cure. N. S. Davis, M.D., Chicago." A glance at the article shows the printer's evil genius has been "at it again." Pregnancy should read "degeneracy." The peccant genius must have been very bad that day!

**PURGATIVES.**—Salines operate in three or four hours; croton oil in one or two hours; jalap, gamboge and senna in three or four hours; rhubarb and castor oil in from four to six hours; aloes and mandrake in from ten to fourteen hours. Some pills in two or three years.

### SOME MISTAKEN IMPRESSIONS IN REGARD TO GENITO-URINARY TROUBLES.

**THE** special mistakes noticed by Dowd are: the belief in the frequency of cystitis due to gonorrhoea, the frequency of vaginitis, the recognition of albuminuria and casts as always indicating nephritis, while they occur frequently during urethral inflammation with no other disease, and the common notion of the greater seriousness of syphilis as compared with gonorrhoea; he also mentions the common belief that twisting or screw-like formation of urination as it emerges is indicative of stricture, which is not the case.—N. Y. *Medical Record*.

**A QUEER VERDICT.**—A despatch from St. Louis to *The New York Times* says that the head of a man, wrapped in an old coat, was found recently in East St. Louis, and when the coroner held an inquest over it a verdict of suicide was returned. We fancy we have seen this story before, or something very analogous thereto.

**DR. MONDE.**—Thyroid extract has been employed with success in some recorded cases of alopecia areata, but it has failed in the hands of others. It is probable that under this designation are included more than one variety of localised baldness, and in any event the constitution of the individual sufferer is a factor not to be lost sight of.

**BRIXTON.**—The charge is a fair one under the exceptional circumstance.

**EDINBURGH STUDENT.**—1. We understand a revised edition is in the press. 2. A question we are unable to answer; write to the publishers.

**MR. F. DENMAN.**—The surgeon named died about two years since. We have no copies of the number containing the obituary notice left. You will find bound copies for reference in your college.

## Appointments.

- ALLEN, W. T. D., M.B., B.Ch., R.U.I.,** Medical Officer for the 4th District of the Parish of Liverpool, vice S. Caldwell, M.B.C.S., resigned.
- COLLISON, HAROLD, M.B.Lond., M.B.C.S., L.R.C.P.,** Resident Casualty Officer to the General Infirmary, Leeds.
- CRAWFORD, E. E., M.B.C.S., L.R.C.P.,** Resident Obstetric Officer to the General Infirmary, Leeds.
- FLEMING, A. D., M.B., M.S. Edin.,** Certifying Surgeon under the Factory Acts for the Kelse District of the County of Roxburgh.
- FOWLER, H. W., M.B. Edin.,** Assistant Medical Electrician to the Royal Infirmary, Edinburgh.
- NASH, J. T. C., M.D. Edin., D.P.H. Cantab.,** Medical Officer of Health for the Borough of Southend-on-Sea.
- ORFORD, T. C., M.B.C.S., L.R.C.P.,** Resident Medical Officer to the Salford Union Infirmary.

**BORIE, GEO., M.B., M.Ch. Edin.,** Senior Assistant Medical Officer to the Dorset County Asylum, Dorchester.

**BUTHERFORD, R. A., L.R.C.P., L.R.C.S. Edin.,** Certifying Surgeon under the Factory Acts for the Kinlough Dispensary District of the Ballyshannon Union.

**SPARKS, J. P., M.D. Durh.,** Medical Officer of Health of Whitley and Monkseaton Urban Sanitary Districts.

**STEVENS, EDGAR, M.D. Aberd.,** Demonstrator in Ophthalmology at University College, Liverpool.

**STREETEN, F. E., L.R.C.P. Edin., M.R.C.S. Eng.,** Medical Officer of Health of Swindon Urban Sanitary District.

**TURNER, D. F. D., M.D. Edin.,** Medical Electrician to the Royal Infirmary, Edinburgh.

**WIGHAM, J. H., L.R.C.P. Edin., L.R.C.S. Edin., I.F.P.S.G.,** Medical Officer of Health of South Molton Municipal Borough.

**WILKINS, A. G., M.B., Ch B.,** Resident Medical Officer to the Salford Union Infirmary.

**WILKINSON, J. HOWARD, M.R.C.S. Eng., L.R.C.P. Lond., D.P.H., Oxon.,** an Honorary Surgeon to the Guest Hospital, Dudley.

## Vacancies.

**Devon County Asylum, Exminster, near Exeter.**—Third Assistant Medical Officer. Salary £125, rising to £150, with board, lodging, &c. Applications to the Medical Superintendent.

**London Hospital, Whitechapel, E.**—Assistant Director of the Pathological Institute. Salary £200 per annum.

**North Wales Counties Lunatic Asylum, Denbigh.**—Second Assistant Medical Officer. £120 per annum, increasing to £160, with board, residence, and washing.

**Nottingham General Dispensary.**—Assistant Resident Surgeon, unmarried. Salary £160 per annum, increasing £10 every year, with furnished apartments, attendance, light, and fuel.

**Oxford, Combined Rural and Urban District Councils of.**—Medical Officer of Health. Salary £750 per annum.

**Royal Sea-Bathing Hospital, Margate.**—Two Resident Surgeons, a Senior and Junior. Salary £120 and £80 per annum respectively, with board and residence.

**Rubery Hill Asylum, Barnet Green, Worcestershire.**—Junior Assistant Medical Officer. Salary £130 per annum, with board, furnished apartments, &c.

**Rural District Council of Bishop Auckland.**—Medical Officer of Health for the Rural District. Salary £350 per annum. Whole time to be devoted to the office. Applications to the Clerk of the Council, Bishop Auckland.

**St. Matthew, Bethnal Green Infirmary, Cambridge Road, N.E.**—First Assistant Medical Officer, unmarried. Salary £150 per annum, with board, lodging, and laundry.

**Somerset and Bath Lunatic Asylum, Wells, Somerset.**—Medical Superintendent. Salary £600 per annum, with furnished house and allowances.

**University of Sydney, New South Wales.**—Professor of Pathology. Salary £900 per annum. Pension £400 per annum after twenty years' service. £100 allowed for passage. Further particulars of the Agent-General for New South Wales, 9, Victoria Street, London, S.W.

**Whitehaven and West Cumberland Infirmary.**—House Surgeon. Salary £120 per year, and £30 per year for Dispensing, with furnished apartments and attendance.

## Births.

**GRUBER.**—On July 23rd, at Neuenahr, Germany, the wife of Karl Grube, M.D., L.S.A. Lond., of a son.

**MACLIE.**—On July 24th, at Wellington, Shropshire, the wife of George MacLie, M.B., of a son.

**MANSSELL-WOODHOUSE.**—On July 21st, at 18, Beaumont Street, London, W., the wife of Walter Manssell-Woodhouse, M.B.C.S. Eng., L.R.C.P. Lond., of Wantage, Berks, of a son.

**WILLIAMS-FREEMAN.**—On July 23rd, at Weyhill, Andover, the wife of John P. Williams-Freeman, M.D., of a daughter.

## Marriages.

**GILLAM-SKIRMSHIRE.**—On July 25th, at St. Andrew's Church, Holt, Norfolk, Joseph B. Gillam, M.B., B.Ch. Cantab., to Dorothy Jane, elder daughter of J. Trusecott Skirmsshire, M.D., of Holt.

**HORSFALL-CAMPBELL.**—On July 24th, at Holy Trinity Church, Melrose, Chas. E. Horsfall, M.B., of Bedale, Yorks, son of the late Hy. Horsfall, M.D., to Lillias Marianne, daughter of E. Hume Campbell, of Glendarnel.

**HILL-FREND.**—On July 24th, at St. Pancras Church, London, Joseph Shuter Hill, L.R.C.P., M.R.C.S., of 22, Mecklenburg Square, eldest son of the late Samuel Hill, M.D., to Rebecca Billingsley, widow of A. B. Friend, Esq.

**HOWAT-KNOX.**—On July 24th, at All Saints' Church, Bakewell, Robert King Howat, M.B., F.R.C.S. Eng., eldest son of Andrew Howat, Hillhead, Glasgow, to Mabel Mary, elder daughter of John Knox, M.D., Church House, Bakewell.

## Deaths.

**BLACK.**—On July 23rd, at Fete du Lion, Valtournanche, Italy (the result of an accident), Robert Black, M.D., of 14, Pavilion Parade, Brighton.

**GORWALL.**—On July 18th, after a long and painful illness, John Hankinson Gornall, M.B.C.S., L.S.A., J.F., during 21 years Medical Officer of Health of the Borough of Warrington.

**SHETTLE.**—On July 21st, at Nailsworth, Gloucestershire, Richard Charles Shettle, M.D. aged 76, for 28 years Physician to the Royal Berkshire Hospital.

**WAVELL.**—On July 24th, at 83, High Street, Newport, Isle of Wight, Jane Searle, widow of Robert Miller Wavell, M.D., J.F., aged 83 years.

# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

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WEDNESDAY, AUGUST 7, 1901.

No. 6.

## Original Communications.

### NINETEENTH CENTURY PROGRESS IN OBSTETRICS AND GYNÆCOLOGY. (a)

By JOHN W. BYERS, M.A., M.D., M.A.O.  
(Hon. Causa);

Professor of Midwifery and Gynecology, Queen's College, Belfast;  
President of the Section.

THIS being the first meeting of the Association held in a new century, it is only natural that we should seize upon the present as a suitable time to look backwards and to ask how have obstetric medicine and gynecology advanced during the Nineteenth Century, a period more fertile in the results of scientific research than that of almost all the years that have gone before. It was during the century that has recently come to a close that the great obstetrician, Simpson, discovered the practical application of anæsthesia in labour, and that the methods of antiseptics and asepsis were gradually evolved; and these two all-important aids have really been the causes of the enormous advances in both obstetrics and gynecology during the past quarter of a century. By their combined help operations (such as the Cæsarean section and symphysectomy) which had formerly been abandoned with regret, owing to their high mortality, have been re-established as recognised safe measures of practice, and many new and improved methods of treatment have been, from time to time, successfully introduced. Conditions which before were regarded as incurable were treated with marvellous success, and, as a result, both diagnosis and technique have been almost revolutionised, because during these operations the obstetrician or gynecologist was brought face to face with situations hitherto undescribed, while, as a further result the morbid specimens removed have given to the science of pathology an enormous impetus by affording an opportunity for the study of interesting material which has not before been described.

In the early part of the Nineteenth Century Nægele's brochure on "The Mechanism of Labour" gave us what Tyler Smith called the "Euclid of Obstetrics"; in more recent years Barbour's "Anatomy of Labour," as studied in frozen sections, has done much to make our knowledge of that interesting process more correct. While the Eighteenth Century will always be remarkable for the work done by William Hunter on obstetrical anatomy as investigated by dissection, the Nineteenth Century has

enormously advanced our ideas of the subject by enabling us—thanks to improved methods—to observe it as presented in a series of frozen sections. By a careful study of these sections, taken at successive stages, we have the whole progress of labour placed before our eyes, and we can follow it step by step as we read the pages of a book. Several of the leaves are still wanting in this volume of sectional anatomy, but, when it is complete, we shall have what I may term a sort of cinematograph representation of the whole progress of labour, which undoubtedly will exercise a most important influence on clinical work. The Nineteenth Century will always have associated with it the practical application of abdominal palpation which is such an addition to aseptic midwifery, by limiting the necessity for frequent vaginal examinations.

It was during the century that is gone that the axis-traction forceps was invented, that the management of the third stage of labour was placed on a scientific basis, and that we have learned better how to deal with such complications as the hæmorrhages which may occur both before and after the birth of the child. Almost all our knowledge of the diagnosis and treatment of extra-uterine pregnancy and of deciduoma malignum has been gained, and by the perfection of other operative measures, craniotomy on a living child has been, we hope, banished. Some in this room remember when it was thought that all lying-in hospitals must be closed owing to their being hotbeds of puerperal fever; at the close of the century we had to admit that in no place is a parturient woman so safe. Turning to the sister science, gynecology, what rapid and brilliant strides it has made in the last twenty-five years! Diagnosis has been rendered more exact by the bimanual method of examination in the dorsal posture. Proper views have arisen as to uterine displacements, and, owing to the success of ovariectomy, not only have thousands of years been added to the sum total of woman's life, but as a result the great triumphs of abdominal and pelvic surgery have followed. Vaginal cœliotomy has been established as a most useful alternative in many cases to abdominal section, and, largely owing to the Trendelenburg position, abdominal hysterectomy for fibroids has become a more and more successful proceeding. Our ideas as to the inflammatory diseases of the appendages and of pelvic hæmatocele have been revolutionised; but with all this enormous progress, there are two subjects about which, unfortunately, we cannot boast—puerperal fever and uterine cancer. It is indeed a terrible blot on our obstetric art, that while within the memory of many of us puerperal fever has been banished from maternities, in which formerly it was so prevalent, the same good results have not followed in general practice. I will give statistics from the three kingdoms,

(a) Address delivered at the opening of the Section of Obstetrics and Gynecology at the Annual Meeting of the British Medical Association at Cheltenham, 1901.

**MORTALITY FROM PUERPERAL FEVER IN ENGLAND AND WALES.**

In 1847-1856 the mortality from puerperal fever was in England and Wales 1·8 per 1,000. It rose to 2·28 in 1875-1884, and to 2·46 in 1886-1895.

The following figures, which I owe to the kindness of Dr. Boxall, who has taken such an interest in this question, give the more recent available statistics.

Year.	Deaths from Puerperal Fever.	Death-rate from Puerperal Fever per 1,000 Births.
1895 ...	1,849 ...	2·0 ...
1896 ...	2,053 ...	2·2 ...
1897 ...	1,836 ...	1·9 ...
1898 ...	1,707 ...	1·8 ...
1899 ...	1,908 ...	2·0 ...

Dr. John Tatham, Statistical Superintendent, General Register Office, has kindly supplied me with the following most interesting details:—

Deaths of women at all ages from puerperal fever and other accidents of childbirth per 1,000 registered births in England and Wales.

1871-80 ...	4·72 per 1000.
1881-90 ...	4·73 "
1891-99 ...	5·12 "

**IRELAND.**

The following return showing the number of deaths in Ireland tabulated under parturition (accidents) and puerperal fever, I owe to the courtesy of Mr. R. E. Matheson, Registrar-General of Ireland:—

Years.	Total.	Death-rate per 1,000 Births Registered.
1895 ...	769 ...	7·2 ...
1896 ...	679 ...	6·3 ...
1897 ...	696 ...	6·5 ...
1898 ...	560 ...	5·3 ...
1899 ...	601 ...	5·8 ...

For the same years the deaths from puerperal fever for the whole of Ireland were:—

Year.	Rate per 1,000 Births.
1895 ...	3·0 ...
1896 ...	2·3 ...
1897 ...	2·1 ...
1898 ...	1·7 ...
1899 ...	2·0 ...

I am obliged to the Registrar-General of Scotland for giving me the following table showing the death-rate from puerperal fever in Scotland during the five years 1895-1899:—

Year.	Number of Deaths.	Proportion in every 100 000 of female population.	Proportion in every 10,000 specified causes of Death.
1895 ...	253 ...	12 ...	62 ...
1896 ...	220 ...	9 ...	63 ...
1897 ...	205 ...	9 ...	52 ...
1898 ...	227 ...	10 ...	59 ...
1899 ...	214 ...	10 ...	54 ...

When we contrast these lamentable statistics with the following returns for the last two years of the practice of the Rotunda Hospital, the largest lying-in charity in the three kingdoms,

**MORTALITY AT THE ROTUNDA HOSPITAL FOR THE YEARS 1898-99 AND 1899-90.**

	1898-99.	1899-1900.
<b>Intern Maternity.</b>		
Total cases ...	1,591	1,560
Total mortality ...	10	6
Percentage mortality ...	0·62	0·38
Mortality from sepsis (2 of these admitted septic) ...	5	0
<b>Extern Maternity.</b>		
Total cases ...	2,163	2,109
Total mortality ...	8	5
Percentage mortality ...	0·36	0·23
Mortality from sepsis ...	2	0
<b>Total cases ...</b>	<b>3,754</b>	<b>3,669</b>

Total percentage ...	0·47	0·27
For two years, total ...	7,423	
Percentage ...	0·39	

they should make those of us who are teachers feel how great is our responsibility, and that our efforts should be redoubled in urging upon students the importance of regarding the process of labour as a natural one, and not to be lightly interfered with unless nature herself should fail, and that if interference became necessary they should use exactly the same antiseptic precautions that they see employed in any gynæcological operation. It is by the observation of these two principles—the avoidance of meddling interference and by the rigid use of antiseptic principles—that we may hope that in the present century the occurrence of puerperal fever will eventually be as rare in private practice as it became in the Nineteenth Century in lying-in hospitals.

The other subject in regard to which, I am afraid, we cannot congratulate ourselves, is cancer of the uterus. How does it originate? Why is it so common? Nay more, why (at least this is my experience) is it becoming more prevalent? These questions surely demand solution. I am reluctantly forced to agree with a statement made by a distinguished American *confrere*, Dr. Baldy, in a paper read before the Section of Gynæcology, College of Physicians of Philadelphia, February 21st, 1901:—“Cancer affecting the cervix uteri is one of the most deadly diseases with which medical men have to deal. By far the largest proportion of these patients eventually die of cancer, be it from the primary lesion or from a recurrence. And this in spite of all that has been done for them either surgically or medically.” No doubt some gynæcologists may say the explanation is that operation is not done early enough, but, as Dr. Baldy fairly asks, “What is sufficiently early?” Every gynæcologist of experience must admit he or she has met with cases where recurrence took place rapidly in what seemed to be at the time of operation a most promising condition, while, again, women with extensive disease have remained well for years after operation. We have passed through the stages of vaginal and of abdominal hysterectomy for cancer of the cervix, but I ask have we up to the present made much real progress? It is not the immediate results of the operation we want to know; it is the subsequent history of the patients. At the present time we can, unfortunately, suggest no other plan of treatment of cancer of the cervix except by operation, but surely we cannot boast much if the statement of Baldy is correct that the most recent statistics, those reported in Cullen’s work on “Cancer,” and the review of cases by Winter of Königsberg, show that in reality less than 5 per cent. of all cases applying for treatment of cancer of the uterus are saved by operation. The obvious lesson is that to ensure any real success we must urge on practitioners the enormous importance of early diagnosis, and that the one symptom which should always be regarded with suspicion is abnormal hæmorrhage. Any woman with abnormal hæmorrhage at any age, and especially if she is over 35 years, demands the most careful clinical examination. Let us hope for greater progress in the future.

Having glanced in what, I am afraid, is a very cursory survey, at the progress of these subjects which specially concern us, let me turn to another question of the greatest interest to the State, as well as to the medical profession. During the present year the public press has been calling special attention to the falling birth-rate. It would appear that in England and Wales, in 1861-71, the birth-rate per

1,000 was 34·8. In 1871-81 it was 34·7, in 1891 it was 31·4 per 1,000, and since then it has steadily gone down, until in the last year of the century, 1900, it was only 29 per 1,000. In 1875, 35 children were born in the United Kingdom for each 1,000 of the population, while in 1900 there were only 29. In other words this means for our population of 41½ millions we are losing 249,000 children annually, and the birth-rate has fallen by 2·67 in the last ten years. The actual increase of the population of England and Wales is due to the fall in the death-rate and the increase of immigration.

We are thus rapidly in England approaching the condition prevailing for some time in France and America. It is not for me at present to discuss the causes of this declining birth-rate, rather my duty is to ask what remedy can we as doctors suggest to combat a state of matters which, from a national and imperial standpoint, must be regarded as unsatisfactory. If fewer children are, in the future, to be born in this country we must redouble our efforts to lower the awful death-rate of infants which, during the first year of life amounts in England to 154 per 1,000, by teaching the people to pay much greater attention to rear their children properly, and by urging the public authorities to provide an adequate supply of pure milk. Our American friends are far ahead of us in such matters, and they showed their usual extraordinary enterprise last summer when they sent pure, non-sterilised milk from various parts of the States (Illinois, New Jersey, and New York) to the Paris Exhibition, where it was actually pronounced better than the average milk sold in the grounds. Quite recently the "Rockefeller Institution for Medical Research," founded by a gift of £40,000 from the millionaire whose name it bears, has decided that the first investigations to be undertaken by the scientific experts connected with it will be to co-operate with the New York Board of Health in studying the milk supply and the contaminated article as a source of danger. But we may also attack this serious problem in another way by taking greater precautions when a woman is pregnant that she may give birth both to a living and healthy child; in other words, we must take more care to combat those conditions which are so dangerous to the child's life before and during its birth. I am afraid it is still too frequently the practice of the present day, when a patient engages a medical man to attend at her confinement, simply to note the engagement, to give a few general directions, or perchance none at all, and, perhaps, in some cases to examine the urine. May I urge that obstetricians should give a much more careful attention to patients who are pregnant, and especially in the case of those looking forward to their first confinement. A pregnant woman, when she engages a doctor to attend her, should be examined as carefully as if she were an applicant for life insurance; in this way he may at an early date detect a flaw in some of her organs (heart, kidney, lungs, &c.), the knowledge of which may lead him to adopt a judicious prophylactic treatment. We should instruct our pregnant patients on such questions as diet, exercise, and management of the secretions; and a most careful examination should be made of the urine from the fourth month onwards, not merely as to the presence of albumen, but in reference to its total amount and the reduction of urea. In this way a form of toxæmia (eclampsia), so fatal to mother and child, may from its early detection be carefully warded off, for it must be admitted that, in the vast majority of cases, the treatment of eclampsia, like post-partum hæmorrhage, is its prevention. Towards the end of gestation a most careful abdominal examination should be made, so that we may learn the position of the fœtus, the amount of liquor amnii,

the presence or not of an abdominal tumour, and, if there is the least suspicion of deformity, the pelvic cavity should be most carefully measured. We must also be on our guard against the dread influence of the syphilitic poison, and the injurious effects of anæmia. In the case of multiparas, an accurate history of previous pregnancies and labours is of the utmost importance. In this way, by a careful, and, if necessary, by a repeated examination of the patient, we may by an early detection of complications ward them off or keep them in such abeyance that their danger is minimised; and if there should be any deformity of the pelvis we can make up our mind what method of delivery is best suited for each particular case. By all these measures we hope that not only a living but a healthy child may be born, and that by our careful management of the patient during and after her confinement no subsequent gynaecological disease may ensue which so often gives rise either to a permanent sterility or to an early subsequent miscarriage.

## THE RELATION OF ALCOHOLISM TO TUBERCULOSIS. (a)

By T. N. KELYNACK, M.D., M.R.C.P.,

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ALCOHOLISM and tuberculosis stand foremost among the causes hampering human progress and limiting man's happiness. Through them the evolution of the race has been impeded, and, unfortunately, in spite of numerous restraining and restricting agencies, their baneful influence is still accountable for a high degree of mortality and an immense amount of sickness and suffering.

Three views are possible: (1) That alcoholism is antagonistic to tuberculosis; (2) that alcoholism bears no special relation to tuberculosis; (3) that alcoholism definitely predisposes to tuberculosis.

### I. ALCOHOLISM ANTAGONISTIC TO TUBERCULOSIS.

Before the true nature of tuberculosis became apparent, the opinion was somewhat widely held that habits of alcoholic excess were antagonistic to tuberculosis and even preventive. This impression still exists among a large section of the public, and is apparently in part due to opinions expressed by many of the earlier writers on pulmonary tuberculosis. Indeed, in some medical quarters such a view is still held. This view was clearly expressed by Dr. Richard Payne Cotton many years since in his Fothergilliam Essay: "It is worthy of remark that the habitual drunkard—he who is always in his cups—is not very often the subject of phthisis; such, at least, is the result of my own observations." The idea that alcoholism was antagonistic to tuberculosis may, perhaps, in part account for the advocacy of its persistent and even excessive use in phthisis.

The abolition of alcohol from many modern sanatoria, however, seems to indicate that, as Dr. Ransome well expresses it, "Owing to the terrible consequences of excess, and to the proclivity of mankind to its excessive employment, it (alcohol) can only be recommended in selected cases with many cautions." (b)

II.—Many hold that alcoholism bears no special relationship to tuberculosis and only exerts an indirect influence in so far as it leads to a lowering of general vitality and places the individual under conditions particularly favourable to the infection of tubercle. And certainly the circumstances attending the life of the chronic alcoholic are

(a) Abstract of paper read before the British Congress on Tuberculosis.

(b) "The Treatment of Phthisis." By Arthur Ransome, M.D. London, 1896. P. 94.

generally such as to specially expose him to the risks of tuberculosis. His habits lead in great measure to an indoor existence, the maintenance of an insanitary environment, insufficiency of suitable food, oftentimes to the influence of depressing emotions; and not infrequently his indulgence necessitates his following an occupation under conditions which are peculiarly inimical to health. Thus, while the influence of overcrowding, neglect, uncleanness, malnutrition, and nerve influences cannot be overlooked, very considerable difficulty attends any attempt to estimate the effect of alcohol *per se* in rendering the tissues peculiarly vulnerable to the tubercle bacillus.

III.—The view that alcoholism definitely predisposes to tuberculosis has of recent years received much support. Indeed, the tendency of modern opinion is to recognise alcohol as an agent, which renders the tissues specially prone to tuberculous infection.

The close association of tuberculosis and alcoholism has now been widely recognised, not only by British physicians, but also particularly by American and French observers. Various suggestions have been made in explaining the liability of alcoholics to tuberculosis. There can be no doubt but that the non-hygienic surroundings and nutritional impairment and lowered vitality of the drunkard greatly predispose him to tuberculous invasion. But it is contended by some that, even besides these factors, there are special influences arising from the action of the alcohol and its associates. Professor Sims Woodhead has recently shown that alcohol has a marked influence in altering or determining alteration of the cells of animals subjected to the action of certain pathogenic organisms. Professor Abbott, of Pennsylvania, and also Dr. Deléarde, working in the Institut Pasteur at Lille, have recently shown that alcoholised animals are more readily infected by many organisms than non-alcoholised animals, and other investigators have also shown that alcohol produces a marked negative chemiotaxis. It has also been found that animals brought into a state of chronic alcoholism are much less readily rendered experimentally immune to microbial infection. Attempts have also been made to show that alcohol, through its influence on nervous structures, rendered the tissues, and especially the lungs, prone to invasion by tubercle. (a)

IV.—In order to compare some of our Manchester experience with the views and opinions above indicated, I have endeavoured to analyse and express the results of observation of hospital cases for a number of years. A reference to pathological data probably affords the most reliable basis for the formation of sound views as to the relationship of alcoholism and tuberculosis.

#### ALCOHOLIC NEURITIS AND PHTHISIS.

Some time since I analysed a number of fatal cases of peripheral neuritis occurring in chronic alcoholics. Eight cases were subjected to pathological examination during a period of three years; they formed 1.6 per cent. of all the medical cases examined during that period. Pulmonary tuberculosis was met with in seven. This gives a percentage of over eighty-seven. All the cases were females. In only one subject were there distinct tuberculosis lesions elsewhere than in the lungs, and then the intestines were also affected. In one subject there was an old tuberculous focus at the apex of the lung, but it seemed probable that the active phthisis was rather due to a fresh infection than from this latent patch. In five cases both lungs were more or less involved; in two

the left was the only one showing any distinct tuberculous process; in three of the cases the course seemed to have been rapid; in four it seemed to have lasted for several months. One subject, it was stated, had "spat blood" six months before her death; in one case one lung only was studded with small tubercles, the injection evidently having been recent; in two there was more or less extensive caseation; four presented evidences of softening and cavitation; and in two of these there was some fibrosis. (a) Since collecting the above I have gone over my more recent pathological notes. Two further cases of alcoholic multiple neuritis have come to autopsy. In one, a male, *æt.* 35, the subject also of hepatic cirrhosis, both lungs were studded with recent tubercles. There was no softening, but caseous foci at the apices were apparent of older formation than the tubercles elsewhere. In the other case, a female, *æt.* 32, in whom there was also a fatty and cirrhotic liver, the lungs, although congested, œdematous, and presenting patches of broncho-pneumonia, showed no distinct evidences of tubercle. Thus out of ten fatal cases of alcoholic neuritis—nine females and one male—eight, or 80 per cent., were the subjects of pulmonary tuberculosis.

In connection with the recent remarkable outbreak of arsenical neuritis in Manchester and district, and occurring principally in alcoholics among the poorer classes, it is interesting to note that in a considerable number of the fatal cases active pulmonary tuberculosis was present, and in some undoubtedly much hastened the end.

Tuberculosis is also of frequent occurrence in the subjects of alcoholic cirrhosis of the liver. In many cases it is manifestly of the nature of a terminal infection.

In order to throw light on this matter, the records of 3,053 medical cases examined in the Pathological Department of the Manchester Royal Infirmary have been analysed. I have collected 121 examples of common cirrhosis of the liver. All doubtful and complicated cases were omitted. Cases associated with cardiac or such chronic affections as seemed to have led to secondary changes in the liver were excluded. All examples of "biliary" cirrhosis and those in any way connected with syphilis have been passed over. After omitting several doubtful cases, in 28 tuberculosis—either active, latent, or obsolete—was present. Thus over 23 per cent. presented evidences of tuberculosis, active phthisis was present in 14, 12 males and two females; and active peritoneal tuberculosis in 12, nine males and three females. Of these, six males and one female had involvement of both lungs and peritoneum. In five males and one female the lungs alone were affected, and in two males and two females the peritoneum alone. No less than 12, or nearly 10 per cent. of the 121 cases, appeared to die directly from tuberculosis. The average age of those in which active tuberculosis was limited to the lungs was just over 44 years.

#### AN INVESTIGATION INTO THE PRESENCE OF INFECTIVE MATERIAL IN DWELLINGS OCCUPIED BY CONSUMPTIVE PERSONS. (b)

By HAROLD COATES, M.D., D.P.H. (Vict.),  
Senior Assistant to the Medical Officer of Health for the City of Manchester.

It is now eleven years since Cornet published the

(a) Kelysack, T. N. "On the Occurrence of Pulmonary Tuberculosis in the Subjects of Alcoholic Neuritis."—*The Medical Chronicle*, 1895-6. Vol. iv., pp. 180.

(b) Abstract of Paper read in the State Section of the British Congress on Tuberculosis.

(a) See "Pulmonary Consumption, Pneumonia, and Allied Diseases of the Lungs." By Thomas J. Mays. New York, 1901. Pp. 61.

result of his investigations into the infectivity of the dust found in the dwellings of consumptives in Berlin, and up to now no work of a similar character has been done in England. In 1895 an investigation of this kind was commenced under the direction of Professor Delépine at Owens College, but was interrupted by other engagements. The establishment of a scheme of voluntary notification of phthisis in 1899 presented a favourable opportunity for taking up the investigation, and acting on the suggestion of Dr. Niven, for whose administrative scheme the reliability of Cornet's results was all important, the Hospitals Sub-Committee of the Manchester Corporation resolved that I should carry out the work under the direction of Professor Delépine, who had previously offered me special facilities for resuming this investigation. Although the plan of the investigation is somewhat different, the methods of experimentation were, in the main, similar to those of Cornet, although modified in some respects at the suggestion of Professor Delépine.

Specimens of dust were collected from situations in which dust from the atmosphere had settled naturally, and where there would be no likelihood of direct contamination with expectoration or by infected articles, except in the disinfection experiments.

The method employed to determine the presence or absence of tubercle-bacilli in the dust was that of the inoculation of a susceptible animal, viz., the guinea pig.

The houses in which investigations were carried out are classified into the following groups:—I. Houses which are in a dirty condition, and in which a consumptive patient is living who is taking no precautions to dispose of his expectoration so as to prevent infection of the atmosphere, but who spits freely on to the floor, or into his pocket-handkerchief, &c. II. Houses which are in a very clean condition, but in which a consumptive patient is living who is not sufficiently careful as to the disposal of his sputa. III. Very dirty houses, in which there has been no case of tuberculous disease for several years past.

In every house the following details were noted:—1. Date of visit. 2. Dimensions of the room examined. 3. Number of persons habitually occupying the room. 4. The conditions of light and ventilation. 5. The state of the walls, floor, and ceiling as regards construction and freedom from dust and dampness. 6. The presence or absence of carpets, curtains, or other objects which afford lodgment for dust. 7. Length of time patient has lived here, and duration of illness. 8. The presence or absence of visible signs of contamination, such as patches of recent or dried sputum on floors, walls, &c. 9. The situations from which dust was taken—always from such a place that direct infection with sputum would not occur.

HOUSES TO CLASS I.

Infected houses in a dirty condition. Twenty-three houses of this class were examined, and in 21 definite results were arrived at. In 13 of these houses at least one animal was found to be tuberculous, and in another house (No. 6) tubercle-bacilli were present in the dust; and, therefore, in 14 out of the 21 houses, i.e., in 66.6 per cent., the presence of infective dust was proved which had at one time been suspended in the atmosphere, and, therefore, was capable of being inhaled. In seven of the houses there was no evidence that the dust was infective.

Altogether, 52 guinea-pigs were inoculated with dust from these houses:—20 of these died within a few days of inoculation; 17 were killed four or five weeks after, and found to be tuberculous; 15 were

killed four or five weeks after, and found to be healthy.

The large proportion of houses—66.6 per cent.—in which the presence of virulent tubercle-bacilli was proved shows what a dangerous accumulation of infective material there is in this class of house.

The effects of overcrowding are not apparent in these results, possibly because the series of houses is too short. In the 14 rooms in which positive results were obtained the average cubic space per head is 457 cubic feet, while in the cases of the seven rooms which did not yield positive results the average cubic space per head is less, viz., 368 cubic feet. The cubic space per head is chiefly of importance in connection with the provision made for renewal of the air of a room. A large cubic space is of little avail if the ventilation is bad. The effects of fresh air and sunlight on the vitality of the tubercle-bacillus are well known. Taking the conditions of lighting and ventilation in these 21 houses which gave the results either negative or positive, we find that out of the 14 positive houses the lighting and ventilation was bad in eight houses, fair in one house, and good in only five; while of the seven negative houses, the lighting and ventilation was good in six and fair in the other one.

In none of the houses with negative results was the lighting or ventilation poor or bad. These facts point strongly to the beneficial effects of light and air, even in the dirtiest houses, where the conditions are certainly not favourable to their action.

In 16 of the houses samples of dust were obtained at different elevations in the room, so as to learn at what points the most dangerous accumulations of infective material was to be found. As was to be expected, those samples of dust taken within one or two feet of the floor produced tuberculosis oftener than samples taken at higher elevations. This greater infectivity of the dust nearest the floor was not due to direct infection with sputum, as all the samples were collected from places where this could not occur. Certain parts of the floor, e.g., near the bedside and near the fireplace in the living room, are the places where the sputum is deposited in largest amount, and where the pulverisation most readily occurs.

SERIES II.—CLEAN BUT INFECTED HOUSES WERE NEXT INVESTIGATED.

Houses which are in a very clean condition, but in which a consumptive patient is living, who is not sufficiently careful as to the disposal of his expectoration. Ten houses of Class II. were brought under examination, and two samples of dust were taken from each house, and each sample was used to inoculate one guinea-pig. Twenty guinea-pigs were inoculated, and of these only three died from acute diseases shortly after inoculation. Of the remaining 17 animals, six developed tuberculosis, and 11 were found free from tuberculosis at the post-mortem examination.

Of the 10 rooms examined, dust capable of producing tuberculosis on inoculation into a susceptible animal was found in five; in one case both animals belonging to that room became tuberculous; in the other four rooms one animal only became affected. Thus, even in the cleanest of houses infectious dust can be found in 50 per cent. of cases when the phthisical occupant is using his pocket-handkerchief or the floor as a receptacle for sputum. It is therefore evident that ordinary cleanliness alone is not sufficient to prevent the accumulation of infectious material in the rooms occupied by a consumptive. The average cubic air space per head in these rooms where infective dust was obtained was equal to 336 cubic feet, and in those rooms which gave negative results 506 cubic feet. In the five

houses where the dust was not infective, in every instance the lighting and ventilation was good. On the other hand, of the five houses which gave positive results on inoculation of their dust, only one had good lighting and ventilation, two had bad light and ventilation, and in two the lighting and ventilation were described as fairly good. Taking the houses of Class I. and Class II. together, the influence of sunlight and fresh air in the prevention of accumulations of infective dust is shown very markedly. In these houses, also, the tendency of the infective dust to settle towards the lower parts of the room is shown.

I have examined 33 houses, of which no definite results have been obtained from two, leaving 31 houses for purposes of comparison.

These results are seen in the following table:—

BERLIN.			
Number of houses examined.	Positive results.	Negative results.	Percentage of positive results out of total.
28	19	9	67
MANCHESTER.			
31	19	12	61

These experiments show that there is a large amount of highly-infective material present in dwelling-houses which are inhabited by consumptive patients who do not take the necessary precaution to destroy their expectorations. Any house where there had been a case of bronchitis or lung affection, meningitis, marasmus, strumous glands, or any case of bone tuberculosis, was excluded. This part of the work was really the one which involved the greatest amount of labour and care, as a very large number of houses had to be investigated before a sufficient number could be obtained in which these requirements were complied with.

The houses chosen for these investigations were all very dirty, and were exactly similar to those of Class I., except that the consumptive patient was absent. Many of them were badly lighted and ventilated, and in all of them there was plenty of dust and dirt on the walls, floors, &c. Ten houses were examined, and in no case was any tuberculous dust discovered.

Twenty guinea pigs were inoculated with dust taken from these houses, and six of these died within a few days of inoculation. The remaining fourteen were killed four to five weeks after inoculation, and all were found free from tuberculosis. These results, taken in conjunction with the results obtained from houses in Class I. and Class II., show that the virulent dust found in those houses is due to the presence of a consumptive patient, who is infecting the atmosphere with his expectorations. These experiments show that living and virulent tubercle-bacilli are present in the dust, which has deposited itself naturally from the atmosphere, in rooms which are occupied by phthisical patients who are in the habit of spitting upon the floor or into pocket-handkerchiefs. They also seem to show that this infective dust is present in greatest amount or is most virulent where the access of sunlight and the free circulation of air is prevented. Such infected rooms must be a source of danger to those occupying them. Healthy persons run the risk of being infected, and the patient himself may become reinfected and his ultimate recovery be delayed or prevented.

It is well known that the tubercle-bacillus can retain its virulence for months in the dry state; it is evident, therefore, that these houses will remain

infective for some considerable time after a patient leaves it. Unless there are some measures taken to remove this infective dust, a new tenant coming into a house lately occupied by a consumptive patient is exposed to the danger of acquiring phthisis. In the poorer quarters of large cities, where houses are too few for the needs of the population, the new tenant often takes possession the same or the following day that the late tenant leaves, and nothing in the way of disinfection or cleansing the walls and ceilings is done. There is no doubt that many persons are in this way unknowingly exposed to infection, and an infected dwelling is in many cases the origin of a case of phthisis which the most careful inquiry has failed to trace to any direct association with a previous case. The same danger exists to some extent at the boarding houses and hotels at health resorts.

Samples of dust collected from various public places have also been examined. Five specimens of dust were collected from the walls at various elevations of the waiting-room of the out-patient's department of the Hospital for Consumption in Manchester. This waiting-room, which is a lofty, well-lighted, and well-ventilated hall, is used by 180 patients every morning. Ten guinea pigs were inoculated and killed five weeks afterwards. None of them showed any signs of tuberculosis. Five samples of dust were also examined from the waiting-room of one of the large general hospitals, but here also the results were negative. Dust taken from railway carriages failed to produce tuberculosis, but two samples taken from a general waiting-room at a railway station both produced tuberculosis.

The method of disinfection in use in Manchester is one recommended by Professor Delépine eight years ago, as a result of experiments which he carried out to test the efficiency of various disinfecting processes. The method is that of disinfection by a solution of chlorinated lime of the strength of  $1\frac{1}{2}$  ozs. to the gallon.

## INJURIES OF JOINTS WITH SPECIAL REFERENCE TO THEIR IMMEDIATE AND REMOTE TREATMENT BY MASSAGE AND MOVEMENT. (a)

By HOWARD MARSH, F.R.C.S.,  
Surgeon to St. Bartholomew's Hospital.

BOTH massage and movements have long been employed in English surgery, but lately they have come into much more general use. Both are valuable remedies, but if used as a matter of routine both may do great harm. As methods of surgical treatment they must always be closely supervised, care being taken to watch their effect, and especially to be sure that no element is present in the case which renders their employment undesirable.

*Physiology of Massage.*—It is necessary to have a clear idea as to what has been termed the Physiology of Massage—as to the different ways, *i.e.*, in which it acts.

1. It enlarges the amount of blood circulating through the part concerned. This is obviously apparent in the skin, which, instead of remaining cold and pale, becomes warm, and more or less red. The same result was experimentally demonstrated in regard to the muscles by Brunton and Tunnicliffe, who showed that the amount of blood passing through them both during massage, and after its cessation, was increased. This increase of blood is in every way advantageous. It maintains or improves the nutri-

(a) Introduction to a discussion, Section of Surgery, at the Cheltenham meeting, July, 1901.



tion of all the various tissues; it promotes the restoration of the functional activity of injured muscles, and it plays an important part in the absorption of lymph and extravasated blood.

2. Its action is mechanical. By kneading and percussion, extravasated blood and lymph which have been coagulated in the tissues, and have led to brawny oedema, are broken up and dislodged, while by stroking from below upwards they are swept onwards and brought within the reach of healthy lymphatics and a normal venous circulation, so that they can more readily be absorbed.

3. It is an efficient stimulant to damaged muscles through its influence on the nervous system. In such minor injuries as sprains and contusions, probably the small nerves ramifying in the injured part are seldom torn across, for they are tough rather than brittle, they are well protected in the subcutaneous tissue and the deeper structures, and their course is tortuous, so that they are quite easily put on the stretch. Nevertheless they are not infrequently so far injured that their functions, for the time being, are more or less suspended, and massage is then a very useful agent in stimulating them to a resumption of activity. It probably acts in a similar manner on the vaso-motor nerves, which preside over the arterial system of the part.

4. No one who has watched its sedative effect when applied in cases of recent injury can doubt the influence of massage in reducing muscular spasm and relieving pain. Here it must be used very gently and be limited to stroking and light friction for short periods three or four times a day.

5. Probably massage promotes the absorption of recently formed adhesions provided they are not too extensive and firm. This is a matter of considerable interest. Just as provisional callus, formed in the repair of fractures, is absorbed, so is the new connective tissue which is developed after injury of the soft parts. Perhaps the most obvious instance of this is met with in the case of adhesions following peritonitis. Even extensive adhesions gradually yet completely disappear, probably as the result of constant disturbance and traction during peristalsis. Much the same result is produced by what may be termed the interstitial disturbance and traction which takes place during the different movements employed in massage.

*As to Movements.*—These are of three kinds: those performed under an anæsthetic; passive movements and voluntary movements on the part of the patient, often carried out against resistance. As to movements under an anæsthetic they can be safely applied only when a careful diagnosis has been made. In the first place it must be ascertained that the joint itself is not, nor has been, actively diseased, so that it has undergone no considerable structural changes, such as follow tubercle, or osteo-arthritis, septicæmia, or locomotor ataxia. The cases in which this form of movement is most successful are those in which the joint itself is practically healthy, while it is hampered by changes in the parts around. Passive movements are chiefly useful in restoring movements that have been lost, or in preventing stiffness in joints which are to be long disused, for instance, a healthy ankle, the patient having disease of the hip or knee. Voluntary movements on the part of the patient, especially when performed against resistance, are in many instances more valuable than massage. Several forms of apparatus have been introduced for use in these movements, and many of them are very satisfactory. In all cases, however, efficient supervision must be maintained.

*Diagnosis.*—Diagnosis is, of course, of essential importance. It cannot always be exact, but it must be carried far enough to indicate that the case belongs

to the general class in which these agents are useful, and that no element is present which renders them unsuitable. The conditions for which massage and movements are suitable are sprains and contusions of previously healthy joints unattended with any serious complication such as dislocation or a fracture, any wide laceration of muscle, rupture or displacement of tendons, or such pre-existent conditions as tubercle, gout, or hæmophilia.

The treatment of recent fractures by massage was so fully discussed at the meeting last year at Ipswich that it is needless to consider it now. The after treatment of dislocations has of late years undergone a great and very advantageous change. In the case, *e.g.*, of the shoulder, the arm is no longer bandaged to the side for a fortnight or three weeks, but passive movements and massage are regularly used after the second or third day. I have seen a patient thus treated able to move his arm freely in every direction in the course of three weeks. I have also seen a patient walk freely and without lameness three weeks after the reduction of a dislocation of the hip. The chief symptoms which indicate the use of massage and movements are stiffness and pain; but before they are employed the cause of the symptoms must be ascertained, as to whether the mischief is inside or around the joints. Take the shoulder. The arm may be stiff and there may be severe pain and marked muscular wasting. Is this a case of disease of the joint itself or of adhesions outside? There is, I believe, only one test to be relied on to determine this question. This is to ascertain whether the joint is as stiff as it at first sight appears to be, or whether, within certain limits movements are free and smooth. If these free and smooth movements—limited though they be—are present, the fact is a strong indication that the joint is sound, and that the symptoms depend on surrounding adhesions. Cases in illustration are related. As to pain it is very important to remember that it cannot be used to differentiate between real joint disease and surrounding adhesions. Indeed, in many cases the relaxed pain due to adhesion is more severe than that produced by joint disease. Muscular wasting—a principal symptom in disease of a joint—may be present, though the case is one of mere adhesion in the capsule and surrounding parts. In some instances movement under an anæsthetic will produce a cure which there seemed at first sight no reason to anticipate, for though the patient complains of “weakness” and pain in the joint there is no appreciable stiffness or any condition for which movement and massage seem called for. These cases, which bone-setters not rarely cure, by moving them as they move all others, are instances of slight adhesions which cannot be detected, but which are yet sufficient to make the patient walk with lameness and “weakness” of the joints concerned. Cases are related to illustrate this group.

## THE PHYSICAL BASIS OF MELANCHOLIA. (a)

By JOHN TURNER, M.B.,

Assistant Medical Officer to the Essex County Asylum, Brentwood.

CERTAIN of the nerve cells of the cortex present an alteration in appearance in many cases of melancholia and dementia (alcoholia). The change is similar to that which follows when the axons of the fore-horn cells or those of the pontiæ nuclei have been severed. But examination of the axons (in the cord) shows that in melancholia the change is not

(a) Abstract of paper read at the Cheltenham Meeting of the British Medical Association, July, 1901.

produced primarily by interference with the axons. The change has also been noted in melancholia by Wigglesworth and others.

The distribution of the lesions were as follows:—The pyramidal and giant cells of the so-called motor cortex show it most clearly; in this region most of the cells being affected. It is commonly met with in the frontal and occipital regions, especially in the large cells of the latter. Of all the nuclei examined in cross sections of the medulla oblongata - hypoglossal - vagus - lateral, ambiguum, gracile, and cuneate, only the first escapes, all the others show the change affecting generally the major proportion of the cells.

In the cord the cells of Clarke's column are early affected and ultimately in advanced cases the fore-horn cells.

In the posterior-spinal ganglia, while only a few cells show the change yet many are altered in another way—densely stained and very shrunken.

In the tracts of the cord only in very advanced cases is there any sign of degeneration of the myelin sheaths, and then it is the crossed pyramidal tract (axons of motor cells of cortex) which is affected.

The pathological observations indicate that the cause which brings about this change is not a general one, operating on all parts of the nervous system, such, e.g., as a perverted state of the blood, otherwise we should expect to find all the cells of a similar type participating in the change. This, as has been shown, they do not. Another point brought out is that the change early affects the afferent cells, and notably those of Clarke's column.

The experiments of Warrington show that this change can be produced in the cells of Clarke's column by division of the posterior roots, and he assumes that in this case it is due to depriving these cells of the ingoing stimuli normally passing to them.

Thus it has been established experimentally that this change can be set up in at least two ways.

1. By agents having a destructive action on the axons of the cells in question (traumatism, and probably also alcohol) and

2. By agents which do not primarily affect the axons of the affected cells

These observations indicate that the melancholic cases fall into the latter class, and, further, that the state of the mind is an essential factor in inducing the change.

The deprivation of the nerve cells of their normal ingoing stimuli is the explanation offered in accordance with the writer's hypothesis (*Journal of Mental Science*, July, 1900) that melancholic states depend on dissolutions of the nervous system affecting the sensory or ingoing section of the nervous reflex mechanism. Clinical observations from Griesinger and other are also given in support of this contention, notably the very general occurrence of anaesthesia in melancholia.

### SOME CONDITIONS OF SUCCESS IN THE TREATMENT OF NEURASTHENICS. (a)

By Dr. A. T. SCHOFIELD,

Honorary Physician to the Friedenheim Hospital, and Victoria Homes.

As this paper deals with treatment only, the word neurasthenia is here used to include all functional nerve cases.

The hints given are grouped around four centres—the physician or the personality, the patient or the

diagnosis, the methods of treatment, and various details.

With regard to the physician, then, sympathy is one of the first conditions of success. It need not be shown, but if felt by the doctor it is felt by the patient, and inspires him at once with confidence. One cannot feel it till one has grasped the fact that a disease of the imagination is not an imaginary disease. The next qualification is *patience*, for want of which number of sufferers remain unrelieved. Allied to this is *perseverance*. Many a successful line of treatment fails to succeed from lack of this. Another is firmness in essentials combined with flexibility in non-essentials. The next quality is tact in mental touch, the "tactus eruditus." Another quality is honesty, not in its mere literal meaning so much as the power of acting solely in the patient's interests as distinguished from that of their families or friends. And lastly, success in the physician depends upon a mind that possesses both the powers of observation and of imagination. Many have the one or the other, but to possess both the gift of accuracy in details with broad and wide views is to be a master in one's profession.

With regard to the patient the point first to decide is the relative part played by mind and body in the disease.

Setting aside so-called "mental cases," we get in "hysteria" lesions of the sub-conscious mind, and in neurasthenia proper, a physical disease of the nerve centres in brain and cord.

The value of these distinctions becomes obvious in treatment.

The distinction between the three groups is not, as a rule, difficult. What is much harder is to discern on which basis of coarse physical lesion the nerve troubles may rest, and this is a point frequently overlooked. Another point with regard to the patient is that he should not have been already a victim of many failures. If he has, the difficulties of cure are greatly increased. Another element of success is confidence in the doctor and nurse. The two indeed must mutually uphold each other, or the most powerful means of cure are neutralised. Again, a correct estimate must be made of the patient's personality and mental calibre, a factor which in the case of ordinary diseases may, as a rule, be neglected. In all these cases the possible sexual basis of some of the symptoms must never be forgotten.

As to methods of treatment, these must be cured away from home; which however much it may at times be a place of rest to men is never so to women, as it is the sphere of their work, and all new cases require rest of some sort. A good nursing home is a *sine qua non*, and is by no means easy to get.

The nurse is a still more difficult factor in the cure. As a matter of fact, while mental attendants and hospital trained, certificated, and chartered nurses abound, the neurasthenic nurse is a rare being to find, and her serious training has hardly yet been evolved.

Finally with regard to details. While, in ordinary cases, rest in bed is nearly always part of the cure, in any with a true mental taint, however slight, it nearly always does harm. Isolation is another point that requires intelligence and not routine in its application, being not always desirable.

Massage is, in most cases, a necessity to aid digestion, but besides this it is of special value in disorders of circulation, wasting or weakness of muscles, stiffness or weakness of joints, pain, congestion of internal organs, and many forms of cardiac disease.

Suggestions play a large part (without any question of hypnotism) in these cases, but seldom can be assimilated in a raw state, but have to be combined

(a) Abstract of Paper read at British Medical Association, Cheltenham, July, 1901.

with various forms of treatment. The management of dyspepsia, sleeplessness, constipation, restlessness, depression, and convalescence, all have an important bearing on the success of the treatment.

Finally, it may be said that the successful nerve doctor owes less to his teachers and more to his idiosyncrasy, experience, and applied common sense than any other variety of medical man,

### Clinical Records.

#### TREATMENT OF WHOOPING-COUGH BY NASAL IRRIGATION.

By EDWARD MAGUIRE, M.D., D.P.H.

FORMERLY the treatment of whooping-cough was most annoying and unsatisfactory to the medical practitioner. Now, I think we may hope we are on the proper track to combat and conquer this most serious and distressing disease. I have for a long time been of opinion that the fountain and origin of this complaint were located in the Schneiderian membrane, and this belief was strengthened by the report of a case by Dr. E. M. Payne, which appeared in a medical journal some weeks ago.

Acting on this hypothesis I have recently treated two cases, a little girl, aged 2 years 3 months, and her brother, aged 10 months, by irrigation of the nares with warmed carbolio lotion in the manner and with results as shown below.

There can be little doubt that the disease is produced by a specific organism, as Afanasjew discovered large numbers of bacilli in the sputum in this disease, and Hewlett, in his "Manual of Bacteriology," says, "Koplik, by sowing the pellets on solidified hydrocele fluid, obtained a pure culture of a small and delicate bacillus measuring 0.8 to 1.7 ins. in length." The bacilli being found in the sputum could be accounted for by the escape of mucus by the posterior nares or by the extension of the disease from the Schneiderian membrane to the pharyngeal or laryngeal membranes.

The strength of the lotion I used was 1-40 with a little glycerine added. I procured a two-ounce syringe with a rubber nozzle, so that when it was in the nares it could not hurt, no matter how the child struggled. Three fills of the syringe were injected into each nostril three times a day. I had only once to show the mother how to use the syringe, and afterwards she and the nurse had very little trouble in using it, although the children were very young. It is a good plan to bind down the arms with a towel or binder before using the syringe.

The following diary, kept by the mother, shows the result of this treatment commenced June 29th:—

		M. McG.	P. McG.
June 25	Number of paroxysms and coughs	7 ...	8
" 26	" "	9 ...	5
" 27	" "	8 ...	9
" 28	" "	6 ...	7
" 29	" "	4 ...	5
" 30	" "	4 ...	5
July 1	" "	3 ...	2
" 2	" "	5 ...	5
" 3	" "	3 ...	7
" 4	" "	5 ...	4
" 5	" "	3 ...	4
" 6	" "	3 ...	2
" 7	" "	1 ...	1
" 8	" "	0 ...	1
" 9	" "	2 ...	1
" 10	" "	1 ...	0
" 11	" "	0 ...	0
" 12	" "	0 ...	1
" 13	" "	2 ...	3
" 14	" "	1 ...	2
" 15	" "	1 ...	2
" 16	" "	2 ...	2
" 17	" "	0 ...	0
" 18	" "	0 ...	1
" 19	" "	3 ...	2
" 20	" "	2 ...	1
" 21	" "	0 ...	1

		M. McG.	P. McG.
July 22	" "	0 ...	1
" 23	" "	0 ...	0
" 24	" "	0 ...	0
" 25	" "	0 ...	0
" 26	" "	0 ...	0
" 27	" "	0 ...	0
" 28	" "	0 ...	0
" 29	" "	0 ...	0

The result in both cases tends to prove that treatment directed to the Schneiderian membrane by thorough irrigation diminishes the frequency of the paroxysms and coughs, and reduces the duration of the disease from months to weeks. Of course, one must not disguise the fact that in this mode of treatment there is a risk of some of the fluid getting into the Eustachian tube.

### Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, August 3rd, 1901.

At the German Congress of Medicine, Hr. Hirschberg gave an address on the

#### OPERATIVE TREATMENT OF HYPERTROPHIC CIRRHOSIS OF THE LIVER.

Our knowledge of the disease was so limited that treatment has not come to the front. In one case, that of a man, æt 51, with great enlargement of the liver, he had achieved a success, that had now lasted for over a year, by operation. Previous to the operation, cirrhosis could not be diagnosed to a certainty. It was rendered probable by the slow development of the disease, by the steady enlargement of the liver, the great and early enlargement of the spleen, the intra-hepatic retention of gallstones, the absence of ascites and of enlargement of superficial abdominal veins, even in an advanced stage of the disease, and finally the fever and the rapid pulse, amounting at times to tachycardia. At the operation the speaker's idea was to conduct the pent up bile to the outside in order to obviate further damage to the liver structures. After cutting into the abdomen he made an opening into the liver the length and breadth of a finger, out of which bile flowed freely. The canal in the liver was plugged with gauze. After its removal a fistula remained which closed at the end of a month. The operation was well borne, and the patient had since gained 25 lbs. in weight.

Hr. Naunyn was not a pessimist as regarded the disease, as recovery in both forms was not so very rare. But he was doubtful whether Hirschberg's case was really one of hypertrophic cirrhosis of the liver. The induration of the liver meant an infection but not purulent cholangitis, a disease that was amenable to treatment of a surgical kind.

Hr. Rosenstein, Leyden, in about 150 cases had never seen a recovery. He also doubted the accuracy of the diagnosis, as there was no jaundice. As regarded the tachycardia the patient might have had cardiac dilatation with liver stasis. It had not been shown, therefore, that operation would be useful in hypertrophic cirrhosis of the liver.

Hr. Hirschberg, in reply, said he must maintain the accuracy of the diagnosis, as the type of the disease could not be otherwise grouped. Hanot himself had acknowledged that there could be hypertrophic cirrhosis of the liver without jaundice. In the bile that escaped through the fistula the bacterium coli was found, but its pathogenic action could not be established.

Hr. Alex. Ellinger spoke on

**THE INFLUENCE OF RENAL INJURIES ON THE COURSE OF PANCREATIC DIABETES IN THE DOG.**

The inquiry was conducted in conjunction with Hr. Seelig. The results were the following: In a case of pancreatic diabetes in the dog acute nephritis was set up by injection of cantharidine, the quantity of sugar in the urine diminished. Not only the percentage and absolute quantity of sugar was diminished, but the proportion between the excreted sugar and the nitrogen became considerably smaller. This influence of the cantharidine on sugar excretion passes away much more quickly than the excreted albumen. If acute nephritis developed spontaneously in a pancreas diabetic dog, the quantity of sugar in the urine diminished, and it could disappear entirely. The disappearance of the sugar depended on efficient excretion from the kidneys, as the quantity of sugar in the blood itself was increased.

Hr. Nannyn intended to apply the experiment to the human subject. He referred to a large number of sugar determinations in the blood of diabetics, where in cachexia the sugar was not increased, but rather lessened, and also to a large number of observations wherein people who had become cachectic (from tuberculosis, for instance), had lost their sugar, although there was no evidence present of renal disease. People who showed sugar reaction whenever small quantities of bread were taken bore large quantities without any excretion of sugar.

## Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, August 3rd, 1901.

**PROTHESIS FOR INCONTINENTIA URINÆ.**

SOME time ago Gersung drew attention to the use of paraffin as a means of obviating the distressing condition of urine incontinence. It is maintained by some that the poison readily passes into the system, their belief being inferred from the nature of the accidents that have sometimes followed these injections. By others it is held to be a dangerous procedure in that it tends to the formation of fatty emboli, which produce serious results when located in the brain.

After extensive practice with paraffin the author is more confident than ever that its use is safe, useful, and beneficially lasting in effect. It should be injected in a semi-fluid condition, with a hypodermic syringe which causes no irritation. It is neither rejected nor absorbed for a very long time, by which time the parts are so changed as to require no further treatment. He relates many cases cured by this method which had defied all operative ingenuity.

**TOTAL EXTIRPATION OF THE VAGINA.**

Wertheim related two cases in which the vagina was removed entirely, together with the other organs of generation, and without any subsequent trouble. After closing the abdominal wound he incised all round the vaginal aperture, and removed the canal *in toto*.

This opinion is confirmed by Guénard, who maintains that the hæmorrhage is easily controlled. He states that he extirpated for myoma and only required three ligatures! The operation, moreover, can be performed in a very short space of time, which is very important in such cases.

**GANGRENE OF LOWER EXTREMITIES.**

Burchard relates a case of some interest in midwifery. Having a breech presentation an effort was made to ease the head by dragging on the body which resulted in decapitation of the fetus. In removing the head an incomplete rupture of the uterus occurred which subsequently left a hæmatoma in the broad ligamentum, and finally a thrombus in the popliteal veins followed by gangrene, for which both legs had to be amputated. The patient ultimately recovered.

**BLENNORRHEA NEONATORUM.**

Zweifel assures us that he has tried all the reputed drugs, including the latest, protargol, without success as a prophylactic in ophthalmia neonatorum, and concludes that nothing succeeds so well as acetate of silver in the form of 1·2 per cent. solution. This may be applied to the eyes without causing pain, the eyes being subsequently washed with a solution of sodium chloride. He instructs all the midwives after washing the child to instill a few drops of the acetate solution wherever (a) there is a history of a previous white discharge, (b) if the same mother has had previous children suffer from ocular discharges, (c) in the case of children whose parents are not particularly clean.

**OBESITY AND THE BANTING TREATMENT.**

A case of Stadelmann's has excited a good deal of interest here, and is worth briefly relating. The patient was a heavy drinker and suffered from alcoholic polyneuritis, yet in spite of the atrophic paralysis of the lower extremities the body weight increased 75 kilos in one year, so that his total weight before treatment commenced was 145 kilos, or 319 lbs.—nearly 23 stones.

From this it appeared that only 1,200 calories were obtained against 2,400 as a normal expression. To restore the equilibrium 1,000 calories required to be taken out of the food, either as carbohydrates or hydrocarbons, and to do this a diet of green vegetables was adopted. Within a year the body weight was reduced 60 kilos, or 132 lbs. He has more faith in the perseverance of the subject in accomplishing a cure than in any drug. The thyroid gland, he affirms, has no influence whatever on the reduction of fat. He is willing to admit that every individual case must be treated on its merits, but he assures us that he knows of no specific drug except those that are likely to produce injurious effects, such as thyroid, the action of which is to produce glycosuria, that modifies alimentation at the expense of the integrity of the kidneys.

The only effect of Oertel and Schweninger's method of fluid deprivation is to reduce the appetite, and thus check alimentary nutrition.

Banting's method with Ebstein's modification of presenting a mixed diet is certainly the most rational method of treatment for reducing fat safely.

**CINNAMON AND TUBERCULOSIS.**

Niehnes is not satisfied with the cinnamon treatment of Landerer in surgical practice. Landerer maintains that cinnamon, when injected into the venous system, produces a sort of aseptic inflammation or leucocytosis, which Niehnes is not satisfied with, but rather holds to the opinion that the cure rests entirely on the drug itself or not at all. In opening local abscesses of a tuberculous nature and dressing with heterocresol and iodoform, more good can be done than by administering cinnamic acid, and this method gives 63 per cent. of recoveries for Landerer's 90 per cent.

In the discussion Vulpis said he had tried Landerer's method in twenty cases, but the rigors and fever were so marked that he has now quite abandoned the treatment.

Niehnes thought the rise of temperature was due to the use of the cinnamon salt of soda.

### Special Article.

#### THE BRITISH CONGRESS ON TUBERCULOSIS.

##### ARTICLE II.

UNDER existing circumstances it hardly seems worth while to devote much space to certain subjects which, but for Professor Koch's startling statements, would have attracted a very great amount of attention, viz., the identification of tubercle-contaminated articles of food, the means of restricting their sale, the prevention of tuberculous disease among cattle, and the question of compensation to be paid to cattle owners for the slaughter of animals recognised to be infected. The papers dealing with these and cognate subjects were extremely numerous, but the discussions to which they gave rise lacked the conviction of opportuneness.

We may therefore pass on to the consideration of the influence of various conditions in determining a liability to infection. According to Professor Koch, heredity may be dismissed as for all practical purposes as non-existent as a source of direct infection. In affirming this truism he did but give voice to a view which has long commanded the assent of authorities in the matter. Hereditary predisposition is quite another thing, though opinions are still greatly divided as to the precise significance to be attributed to this factor in determining an exaggerated proneness to the disease. According to Dr. Squire, although some 33 per cent. of consumptives present a family history of tuberculosis, there are statistical grounds for attributing the disease to occupation and surroundings in by far the greater number, thus reducing the possible influence of heredity to 9 instead of 33 per cent. Attacking the subject from another point of view, he found that out of 469 claims under life insurance policies, 78 were from consumption and other forms of tuberculosis, and of these 78 only 7 had any history of consumption in the family, while a phthisical history was obtained in 22 cases in which death had taken place from some other cause than tuberculosis. This gives 440 cases free from consumptive taint, of whom 71 died of tuberculosis = 16.13 per cent.; and 29 cases with consumptive family history, of whom 7 died of tuberculosis = 24.13. These figures are too few, of course, to be of much value by themselves, but they are interesting as tending to confirm the opinion now very generally accepted, that the direct influence of heredity in tuberculosis is considerably less than was formerly supposed. Dr. MAXON KING, of New York, goes even further than this, for he inclines to the opinion that in many instances a certain degree of immunity is conferred upon the offspring of phthisical parents. He bases his views on 242 carefully recorded observations of tuberculosis in which he had opportunity for close personal study into the immediate family histories and such other features of the cases as would throw light upon the inquiry. Of the 103 fatal cases among this number he notes that 76 occurred among individuals of non-tuberculous parentage, the average duration of the disease in these cases from its

earliest signs to death being 2.93 years. The other 27 fatal cases occurred among individuals of tuberculous parentage in whom the average duration of the disease to a fatal issue was 4.01 years. We need not go into the details upon which he bases his conclusions, which are as follows:—1. That the percentage of consumptives having a tuberculous parentage is actually smaller than that not having a tuberculous parentage, and is much smaller than would be more than accounted for by the additional danger of infection to which the former class is subjected. 2. Tuberculosis in the parents render the offspring immune to a not inconsiderable extent, as shown by increased resistance to the progress of the disease and an increased tendency to recover among this class.

Among other factors which appear to influence the mortality from tuberculosis, Dr. VON KOSOV, of Budapest, incriminates the youthful age of the parent or parents. He found the mortality among children whose mother was under 20 to be 8.45 per cent. This proportion fell to 5.09 when the mother was between 20 and 30; to 2.78 between 30 and 35; with a rise to 4.26 when the mother was over 35. On the paternal side the mortality among the offspring of fathers under 25 was 5.71; between 25 and 30, 4.74; 3.81 between 30 and 40; with a similar rise to 6.01 per cent. when the father was between 40 and 50. These figures are not without interest in respect of the proper age for marriage.

We talk of a predisposition to tuberculosis as if it were a more or less fixed quantity, though, after all, it is merely a matter of appreciation. Dr. ALBERT ROBIN, of Paris, read a paper in which he showed that predisposition is not a mere figure of speech, but that it corresponds to certain well-defined and recognisable peculiarities of the respiratory exchanges. A study of these exchanges enables us to recognise predisposed subjects beforehand and consequently to submit them to a hygienic and therapeutic regimen capable of modifying the functional and nutritive fault which is the necessary antecedent condition for the development of the bacillus. The respiratory exchanges are found to be increased in 92 per cent. of the subjects of confirmed tuberculosis and in 63 per cent. of those with tuberculous heredity. Alcoholism and various forms of overwork increase the respiratory exchanges, and are thus capable of creating a soil for tuberculosis in the same way as heredity. From this observation he deduces a means of testing the value of treatments according to their action in modifying the respiratory exchanges.

The treatment of phthisis by climate and by "open-air" being very much in vogue, a special interest attaches to a paper by Dr. W. GORDON, of Exeter, who has studied the influence of wind *per se* on prevalence of phthisis in his part of the country. He finds that the distribution of the phthisical death-rate cannot be explained by peculiarities of soil or rainfall, sunshine or purity of atmosphere or differences of sanitation, occupation, race or intermarriage; in short, he thinks the excessive mortality in certain districts can be fully accounted for by the influence of exposure to west and south-west winds. It would appear that the influence of these winds is not due so much to their coming from any particular quarter or to any peculiarity in the matter of temperature, moisture, &c., but to the fact that the prevalence of wind leads the inhabitants to

keep their windows and doors shut night and day, thus creating a condition of non-aeration comparable to that which obtains in cities from deficient air space, overcrowding, &c. This argument is not without its importance in that it establishes the importance of choosing a sheltered spot whereon to erect sanatoria. The thing is not to exclude any particular wind, but to exclude great movements of air which make living in the open air uncomfortable. Although wind *per se* does not directly create any liability to tuberculosis, it does appear to exert an inimical action on those who are actually suffering from pulmonary tuberculosis; another reason for excluding wind from sanatorium grounds.

There remains the subject of treatment of tuberculous affections by drugs and sera, and this may be dismissed in a few words. Dr. G. A. HERON reported fairly good results following treatment by injections of Koch's tuberculin; sixteen out of fifty-seven cases having recovered. He attributed the discredit into which this method of treatment had fallen to its use in unsuitable cases and in too large doses. On the whole, he considered it as safe as any other potent drug. Professor Koch himself was much more guarded in his utterance. He stated that his tuberculin was valuable in cases of apical pneumonia, especially when influenza was suspected, also in cases of pleurisy. In early uncomplicated cases of phthisis it was, he said of great value and a complete cure frequently followed, but to obtain its maximum good effects the temperature should be normal before the injections were begun. In the discussion that followed, in which a large number of well-known authorities took part, the almost unanimous opinion was adverse to the use of this substance, and this no doubt represents the opinion of the profession at large.

The voluntary notification of cases of pulmonary tuberculosis, as set forth in a paper by Alderman McDougall, of Manchester, has much to recommend it as affording the means of ascertaining the prevalence and distribution of the disease. Its benefits, however, are not merely statistical. A knowledge of the local distribution of the disease enables the sanitary authorities to inquire into the sanitary condition of the house or district, it enables advice for preventing the spread of the disease to be given and proper sanitary precautions enjoined. Then too, the sufferer, if of the labouring classes, can be removed to a hospital or sanatorium when such are available; and, lastly, it enables the medical officer of health to insist upon adequate disinfection of the premises after death or removal of the patient. This system can only be resorted to with benefit in districts where advantage can be taken of the knowledge thus gained to carry out the consequential measures.

The infectivity of houses inhabited by the phthisical is a point upon which definite information was greatly needed. Dr. HAROLD COATES, of Manchester, brought forward some interesting observations bearing on this point. He classifies the houses with a phthisical inhabitant into dirty and comparatively clean, with a third group of very dirty houses without any tuberculous inhabitant. In twenty-three houses described as "dirty and inhabited by a consumptive patient" fourteen were found to contain infective dust, equal to 66·6

per cent. His conclusions point to the fact that while light and air are highly important, cubic space without ventilation is of no avail. Of ten houses described as "clean but inhabited by a consumptive patient," infective dust was found in 50 per cent. He concludes, therefore, that ordinary cleanliness is not sufficient to prevent the accumulation of infective material in rooms inhabited by a consumptive. The importance of lighting and ventilation was shown by the fact that in all the rooms where no infective material was found both were good. Out of ten houses described as "very dirty but in which no tuberculous disease had existed for several years," in none could any infective dust be found, so that the inference is that the virulent dust found in houses of the first two categories was derived from the consumptive persons. Incidentally he laid stress upon the importance of the thorough disinfection of dwellings which have been inhabited by the phthisical, an argument which will command ready assent.

Naturally, the provision of sanatoria came in for full consideration. It was recognised that vastly-increased accommodation is required if any impression is to be made on the prevalence of the pulmonary tuberculosis in our midst, not only for the purpose of placing the victim of the disease in an environment favourable to his restoration to health, but also, and this is not the least important, in order to remove a potent source of contamination from his family and the district. The only point calling for notice in this connection is the fact that it is unnecessary to wait until funds are provided for the construction of large sanatoria fitted with all the therapeutical luxuries of modern science. It was urged that a vast amount of benefit could be conferred by camp sanatoria—that is to say, by the provision of more or less inexpensive constructions—tents, huts, and the like. In these medical supervision would be reduced to a minimum. The great thing is that such encampments might be created all over the country with the assistance of local authorities or by private benevolence, and in view of the small cost of maintenance they might easily be made self-supporting.

## The Operating Theatres.

### THE CHELSEA HOSTITAL FOR WOMEN.

**NEPHRECTOMY AND APPENDECTOMY.**—Mr. BLAND-SUTTON operated on a woman, *æt.* 46, on account of an obscure pain in the right side of the abdomen, which was at times accompanied by a definite "swelling." The patient had during the preceding five years seen several physicians and surgeons, who had found it difficult to determine between an intermitting hydronephrosis or distension of the cæcum. Mr. Bland-Sutton, after careful observations of the patient, found it difficult to decide whether the right kidney or the vermiform appendix was the source of trouble, and determined to explore the parts through an incision in the right linea semilunaris. On exposing the parts a very long (6 ins.) vermiform appendix was seen lying parallel with and adherent to the cæcum and ascending colon. Its distended tip was in actual contact with the gall-bladder. The appendix was removed. The right kidney was completely disorganised, and its pelvis with the adjacent segment of the ureter was dilated into a large sac. On careful examination he assured himself that it would be

judicious to remove this troublesome organ, especially as the left kidney appeared to be sound and efficient. Nephrectomy was carried out without any difficulty, the large flaccid renal pelvis being carefully dissociated from the vessels before they were ligatured. The abdominal incision was sutured in three layers and without drainage. Mr. Bland-Sutton observed that the case was of interest because pains in the right side of the abdomen accompanied by a swelling, permanent or temporary, were often puzzling. Thus a gall-bladder might be so distended with pus, and reach so low as to simulate an appendix abscess, and he had evacuated an abscess, of which the gall-bladder formed part of its wall as high as the right costal arch, which contained the detached tip of the appendix. He pointed out that an ovarian abscess or a distended Fallopian tube adherent to cæcum simulated appendix trouble so closely that the distinction was only possible on actual inspection. Further, it was often extremely difficult, he said, to diagnose an acutely inflamed and distended gall-bladder from an acute hydronephrosis, or a chronically inflamed gall-bladder from a movable kidney. In doubtful conditions it was, he thought, always wise to carefully inspect the swelling through an incision in the abdominal wall, and then act according to the organ which is the source of trouble: it may be colon, cæcum, or appendix, kidney, liver, gall-bladder, or perchance the pylorus. Often it is the ovary or Fallopian tube.

The patient made an uninterrupted recovery.

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## The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, AUGUST 7, 1901.

### THE WORK OF THE METROPOLITAN ASYLUMS BOARD.

THE Annual Report of the Metropolitan Asylums Board furnishes an interesting account of the progressive administration of various Poor-law and municipal institutions. As a record of vigorous and enlightened administration it is of value to local bodies in all parts of the United Kingdom, and, for that matter, of the whole of our world-wide empire. The work of the Board is multifarious and important

including, as it did, for the year 1900, the care of 5,727 imbeciles, of 5,180 fever patients, of 1,492 small-pox patients, and of 860 children in homes, or a grand total of 13,266 persons at a cost of £832,465. One of the most arduous additional duties consists in the conveyance of 33,791 infectious patients to and from hospital. This branch of the administration involves a large staff of servants, and its services are available daily throughout the year. Some idea of the magnitude of its operations may be gathered from the fact that during the year the ambulances of the various stations covered in all a distance of 232,848 miles. There are also three ambulance steamboats and an ambulance steam launch in working order, and these together have conveyed 1,635 patients, and covered a distance of 4,757 miles. It is interesting to note the growing popularity of the infectious hospitals, which are open to any persons irrespective of their social position. In this connection the Report states that the increasing use of these institutions by the public has been one of the reasons that have compelled the Board from time to time to extend their building operations. But there are other causes at work, namely, the additional accommodation required by imbeciles, and the increase in the various classes of poor children entrusted to the care of the Board. With regard to the latter point it is a matter of some surprise that a public body with practically unlimited funds at disposal should be obliged to record another year's delay in carrying out the provisions of Mr. Chaplin's famous Departmental Order. The task of finding accommodation for the five classes of Poor-law children was handed over to the Asylums Board. The specified classes fell under ophthalmia, ringworm, convalescent, and mentally defective and remand children. The present position may be summed up in the statement that neither ophthalmic nor ringworm children are yet received, although accommodation has been provided for 160 of the latter class, a mere fraction of the total number thus affected. Homes have been founded at Herne Bay and at Margate for convalescents. Some slender accommodation has been provided for this defective class, but none at present has been obtained in the case of children under remand from the police courts. After making every allowance for the legal and other difficulties of the situation the Asylums Board can hardly be said to have risen to the present occasion with their usual energy and thoroughness. During several years they have been enabled to deal with Poor-law ophthalmic patients only by availing themselves of that most excellent pioneer institution, the ophthalmic isolation schools at Hanwell. The Board have secured two sites for children suffering from ophthalmia, namely, at Brentwood, in Essex, and at Swanley, in Kent. The total cost of those institutions will be very great, but economy has never been a strong point with the Asylums Board. However, the money thus spent will not be grudged by the patient ratepayer, provided it be shown that he

obtains in return accommodation of ample dimensions and first-rate quality. £832,465 18s. 5d. is a large sum to pay for the various purposes of the Board, but it is a relatively small sum if regarded in the light of an insurance premium paid for the protection of the public as far as may be against the costly inroads of infectious disease. In the course of time it may confidently be hoped that preventive medicine, of which the Asylums Board is a faithful and powerful handmaid, may extend control over the additional scourges of measles and whooping-cough. In that event the Board will be called upon to make fresh efforts, although it may reasonably be expected that some of the diseases which now tax their energies may have notably diminished. Everyone interested in the problems of modern social life will do well to study carefully the admirable Report of the Metropolitan Asylums Board for the year 1900.

#### "LATENT" FRACTURE OF THE SPINE.

MUCH comment has been aroused in medical circles in Dublin concerning the sudden death of a pharmaceutical chemist, which took place on July 20th. It would appear from the account in the public press of the evidence given at the inquest held on July 22nd, that the deceased told his assistant, when the latter arrived at the shop at about nine o'clock on the morning of July 19th, that he had fallen down the cellar stairs. He complained of having hurt his ankle, but otherwise appeared to be in good health. About an hour afterwards he got on his bicycle to ride to the Meath Hospital Dispensary, and this he seems to have been able to do without much distress. He returned to the shop at one o'clock, and attended to business there until about half-past two o'clock, complaining only of his ankle. A second witness who saw him at this hour corroborated this account. A third witness who had called at the shop at three o'clock to get a prescription compounded, deposed that the deceased complained to him of having fallen downstairs and dislocated his ankle, and said that he had telephoned for a doctor but could not get one. The witness offered to take him in his trap to a doctor. The deceased hopped on one foot to the trap, which he entered without assistance. The witness subsequently returned with him to the shop, and, during the whole time he was with him, he had no reason to suppose that he suffered from any other injury than an injured ankle. Later another doctor saw him, and ordered a lotion which contained opium to be applied to his ankle. The deceased chemist's brother saw him in the evening just after this doctor's visit, and found him lying in his clothes on his bed. He complained of pain but without specifying where he felt it till he attempted to remove something from the pocket of his brother's trousers when he made complaint of pain in his back. The deceased asked him to walk quietly in the room as the least vibration hurt him. The deceased appears to have been alone from about

eight o'clock in the evening until eleven when his brother returned and remained with him. The deceased was alive at about 2.30 a.m. on the 20th ult., but when his brother awoke at 7 a.m. he was found to be dead. At the post-mortem examination performed by the last doctor who saw him alive, a second doctor being present, the posterior cervical region was carefully examined in consequence of a large extravasation being noticed in that region, and a fracture of the left articular process of the fourth cervical vertebra was found with extra-dural effusion. The spinal cord does not, however, appear to have showed signs of gross laceration or compression. The brain was examined, but nothing else was found to account for death. The analyses of the contents of the stomach failed to show that the deceased had swallowed any of the lotion, as was apparently suggested. It appears from the evidence that the unfortunate man not only attended actively to his business after the fall which injured his ankle and, it must be assumed, fractured the spinal articular process, but even rode his bicycle, and hopped to and from a trap without complaining of pain in his neck or back. The doctor, to see whom he was driven, was not called at the inquest, nor was evidence taken from those who were on duty at the hospital. That a man may walk about almost immediately after having sustained a fracture of the upper cervical vertebræ, and resume manual labour after a few days, has long been recognised, but it nevertheless must strike one who judges the case from the report of the evidence published in the public press as extraordinary, that, with such a lesion as was found post-mortem, pain in the region should be so little complained of, and that the movements of the neck should be so free that though several skilled medical men and others saw the patient their attention does not seem to have been called to his neck. It seems hard to understand why death should have taken place unexpectedly, even supposing that the roots of the phrenic nerve "were so compressed by extravasated blood that it ceased to carry on its functions," one would expect that its fellow would have done duty sufficiently long to allow warning of impending danger. The cord itself was apparently found to be compressed by the hæmorrhage or fragment of bone. Paralysis of the diaphragm alone can be but very rarely a cause of such sudden and unexpected death. The coroner was perfectly justified in his selection of the medical attendant—whose ability no one will question—to perform the post-mortem examination. At the same time it would perhaps have been more satisfactory if, instead of the parts removed being brought (as was done) to a skilled pathologist, the pathologist had been brought to the post-mortem examination in the first instance. We are far from intending to infer that the examination was not satisfactorily performed; the known and acknowledged ability of the gentleman who performed it is a sufficient guarantee that it was, even had he not had a second medical man present during



its progress who corroborated his evidence. It is to be hoped that an authorised report of this extremely important and interesting case will be published in detail, as it would seem to fall under the head of the rare condition known as a "latent" fracture of the spine—a name given years ago to such cases by Simon.

#### SCIENTIFIC EDUCATION.

THE President's Inaugural Address at the Cheltenham meeting of the British Medical Association had many features of interest, notably the learned and attractively written historical retrospect. On this alone we might comment at some length. But we refrain from doing so in order to throw into stronger relief a matter of equal interest and even greater importance, the plea, namely, for better and more widely-diffused scientific education in our land. Dr. Ferguson dwelt on the striking fact that many of our most far-reaching discoveries in connection with the healing art had been the work, not of the men in the actual practice of the profession, but of pure scientists, both biologists and chemists. True, had he chosen to illustrate the value of the work of practical medical men, he could have found examples sufficient; but let that pass. For the present we may follow the President's line of argument; the deduction from his theme was the value of a pure scientific education, and he found opportunity for making some most important corollaries on the subject. He somewhat mournfully pointed out that the want of scientific technical education was driving out much manufacture from this country; taking as an example the aniline dyes, he reminded his hearers that while the discovery of these dyes was the work of an Englishman, the process of their manufacture now practically lay in the hands of a German firm, employing hundreds of analytical chemists, and thousands of workmen. He uttered a warning that has been uttered before, and that may require frequent repetition before we as a nation take it to heart, that an extension of this principle will mean untold financial loss to this country. And the loss will be all the greater because it is not only a question of a present pecuniary disadvantage; the worst feature of the business is that the mental capacity, ingenuity, and resources of our young men are not being exercised, and consequently we must necessarily get left further and further behind in the great world-competition. Dr. Ferguson warmly contended that a country which had produced the epoch-making discoverers of the last century was not barren either of genius or of industry; but our sons must have a fair chance, they must not be hopelessly handicapped. The moral and the remedy are clear, nor did the orator fail to point the one and define the other. We must have more scientific and technical training at our universities, available not for the few but for all; we must insist that the work of a university is not primarily to examine, but to teach; and not only to teach, but principally to train up the students to investigation and research, and to bring

out and develop all their faculties of thinking for themselves. In a word, they must be taught to use and apply as well as to acquire knowledge. Schools of engineering, of applied chemistry, of technical industries, of biological research, must be multiplied and endowed. Naturally we look first to the State, but the State, like Jerusalem of old, is slow to perceive the things that make for her good, and slower still to act on these perceptions when they are acquired. Failing the State, we must look to the public-spiritedness and the generosity of our wealthy men. Fortunately there are not wanting signs that the hour will bring forth the man; the recent munificent gifts to the Scotch universities are fresh in our memories. But must we long wait for the fulfilment of the aspiration that the Twentieth Century will see the establishment in every great city in our land of a true university, well-endowed and amply provisioned for thorough training in all those branches of pure and applied science on the development of which commercial and social prosperity depends? For these things did the great Huxley labour and contend. May that mighty force, a nation's conscience, soon awake to insist on their fulfilment!

#### Notes on Current Topics.

##### Signal Success of the Revolt Against "the Flannery Clauses."

It is with unalloyed satisfaction that we announce to our readers to-day the complete success of the indignant revolt of members of the profession, headed by the Bradford and West Riding Medical Union, against the oppressive, insulting, and heartless duties which Sir Fortescue Flannery, M.P., proposed to inflict on them by obligatory penal clauses in the Factory Bill now before the House of Commons. We gladly gave our support to the movement in opposition to those clauses, and in our issue of July 17th condemned them root and branch. The success of our opposition has been complete; Sir Fortescue Flannery has unreservedly withdrawn his indefensible proposals, and we are undisputably victorious. Such a rapid success was hardly to be anticipated. One naturally supposed that Sir Fortescue Flannery would not have dared to propose such an unparalleled amendment attacking alike the sacred privilege of a dying patient and his friends, and the rights and duties of the medical attendant, unless he had fortified himself with what he regarded as incontrovertible arguments in his favour, and we supposed he would have fought hard to defend his cause. But we did him wrong in this. Having proposed to inflict unjustifiable indignities on the profession, and to make the sick room the scene where the doctor would have to struggle with patient and friends to secure a sample of the patient's blood, Sir Fortescue has proved by his sudden surrender that he feels he had no justification whatever for his proposals. The absurd and unworkable character of the wording of his clauses is in itself proof of how lightly he regarded

the seriousness of what he was attempting. He is probably to-day a wiser and a sadder man. Had he not surrendered unconditionally the opposition would have resisted him to the bitter end, and every form of the House of Commons would have been employed against him, even to the last resource of destroying the whole Bill. This uncompromising attitude is the only one which need ever be adopted if success is wished for, in resisting such nefarious attempts. For the profession has unfortunately allowed itself to become a bye-word for want of power of resistance and apathy. Hence the increasing number of penal enactments to compel medical men to render obligatory services to the State. They alone, of all subjects of this realm are forced, to give to the public, by Act of Parliament, the fruits of their study and experience. To them alone has Parliament dared to say, "The fruits of your toil shall not be your own, you shall render them to others, who have no right or title to them, except that those fruits are valuable and very useful." THE MEDICAL PRESS AND CIRCULAR has always upheld the rights of the profession, and of all the medical journals in the country it alone has entered the lists against the Flannery clauses. It is with supreme satisfaction we record the fact and the victorious result. This notable success is another illustration of how great is the power which the medical profession possesses if it will only rouse itself to promote its own interests. THE MEDICAL PRESS AND CIRCULAR is always ready to support these interests, which form the object of its existence. Never have our columns been closed through self-interests to the greater claims of the noble profession whose organ we are. We cannot conclude without drawing the attention of the profession to the great debt which is due to the Bradford and West Riding Medical Union for its splendid service in the matter, and in particular to its President, Dr. Goyder, and to Dr. Hime, who have done yeomen's service. It is not the first time Bradford men have won notable victories for the profession, exhibiting an example of unity, energy, and success which is an object lesson to the country. This contest has not been a local one in defence of Bradford interests. The Flannery clauses trampled on the rights of every medical man in the country.

#### The Lady Doctors' Opportunity.

OWING to the absence at the front of so many young surgeons there is a striking difficulty in obtaining candidates for resident posts in hospitals and public dispensaries, especially in the provinces. So much is this the case that in quite a number of instances the only candidates have been qualified women, and they have accordingly been appointed. A contemporary points out that if the present dearth of candidates for the Services continues the Government may seriously have to consider the propriety of employing female labour. The authorities have a rooted objection to the employment of women, as evidenced by their obstinacy in withholding a supply of nurses at the front until public opinion became too

strong for them. We doubt, however, whether public opinion would view with complacency an innovation in this direction, and the British soldier, who at heart is a modest being, would probably resent being obliged to unfold his tale of woe to an adviser of the opposite sex. One of the most distressing consequences of the dearth of unattached medical men is the difficulty with which practitioners, desirous of enjoying their well-earned repose, find in providing substitutes. As *locum tenens*, the lady doctor presents certain incontestable advantages. She is sober, assiduous, and socially trustworthy. Nothing is farther from our idea than to insinuate that the male *locum tenens* is the reverse of this, but it is notorious that a certain proportion of the gentlemen who are willing to serve as substitutes present drawbacks of a more or less serious kind. Still the moment has not yet arrived when the average practitioner could safely entrust his *clientele* to the safe keeping of a lady substitute be she never so well suited for the post.

#### The Mechanical Side of Surgery.

WE are constantly being reminded that there are a great many things which the ever busy student is not taught. A surgeon, inspired no doubt by the fact that he resides in Toledo (Ohio), complains that students are not taught how to sharpen their scalpels. Now it is a matter of fact that a very large proportion of surgeons would further impair the cutting edge of a knife if they tried to confer upon it the indispensable sharpness. This consideration prompts the author to lay it down that no person should be allowed to practise surgery without first learning a mechanical trade. No doubt manual dexterity, however acquired, is a precious quality in every walk of life, but in deference to the principle of the division of labour we have allowed ourselves to fall into the habit of delegating these details to the surgical instrument maker. The important points to be remembered in "boning" a knife, it appears, are to pull it along the stone from heel to point with the cutting edge forward at an angle of about 45 degrees. When "stropping" a knife, on the contrary, it should be drawn from heel to point *away* from the cutting edge. If this information should be the means of obviating the necessity of any of our readers taking out a course in a workshop we shall have earned their thanks.

#### The Difficulties of Medicine.

THE address in medicine which Dr. J. F. Goodhart delivered at the annual meeting of the British Medical Association at Cheltenham is characterised by a Montaigne-like chattiness which made it pleasant to listen to in spite of its genially cynical tone. Dr. Goodhart had no pet theme to discuss, and apparently no particular moral to enforce, but he delivered himself of a series of more or less discursive remarks on medicine as it is practised, which must have convinced his audience that "the best of us are but gropers in the dark," though "any

fool can give a name to a disease." Fortunately Dr. Goodhart regards the prevailing ignorance with philosophical indulgence, he does not twit us with knowing so little, all he asks apparently is that, knowing so little, we should not pretend to know so much. He even goes so far as to palliate our shortcomings in view of the difficulties which hem in research on every hand. We have heard a good deal of late, he observed, about water tube boilers, their intricacy of working and their excessive wear and tear, and the difficulty of their repair without stopping the ship. What, he asks, would be the position of the engineer if such a vessel could be worked automatically with the hatches down, positive knowledge of the condition of its entrails being obtainable only by the observation and analysis of the smoke and bilge water, by post-mortem examination at the breaking up of old vessels and the recording where each had gone to pieces? Yet that is the position of the medical practitioner when he attempts to modify or control function. Fortunately the animal organism has the advantage over the vessel of a certain self-righting power, but this again is an unknown quantity, and not even the wisest among us can foretell with any approach to certainty whether in a given case the disturbance is one the remedy of which it is within the power of the organism to compass.

#### Let the Hire be Worthy of the Labourer.

ONE reason why the public as a rule set so little store by medical advice is that medical men weakly allow themselves to be cajoled into perpetuating the popular belief, the product of the thought which is child to the wish, that for every disease there is an appropriate remedy. None better than the medical practitioner knows that in the vast majority of cases which come under his notice it is advice and not medicine which is needed, yet the courage fails him to declare the fact and to act on it. This may, as suggested by Dr. Goodhart in his address at Cheltenham, be one reason why people accept and pay for advice from lawyers readily enough while they fail to appreciate medical advice pure and simple. Advice, he exclaimed, just think of it! A product of so unique a value, that when a man of great experience in the world of medicine dies his knowledge dies with him; no other man can supply his place, and there is a dead loss to the community of a mine of unrealised information. Referring to a very very clever signboard in which a bullock is seen gazing yearningly upon a small jar of meat extract and exclaiming "Alas! my brother," he said he wished he could pot brothers as they flitted from off the stage; his trouble was that his great masters died unbottled. And yet we "give" advice, and there are those in number who not only accept but ask the gift. And this advice, it has been asserted, is dispensed upon the strictest trades union principles which have been defined as "doing the worst possible work at the highest possible price." Why, it is

notorious that such is the generosity of medicine that there is not a needy person in the whole kingdom who cannot, if he need it, obtain the best opinion in the country gratuitously. The clergy, the army, the navy, artists, actors, actresses, clerks, artisans, and others, pour into a doctor's room or the hospital asking alms in the shape of advice and never get a refusal. And after it all we are insulted by being called trades unionists—"men who do the worst possible work at the highest possible price!" Verily we have ourselves to thank for this in great measure, for we belittle the value of our advice in allowing the public to exalt so greatly the supremacy of mere physic. The labourer is worthy of his hire is but one side of the question, and not the best side; for it might be held to cover many a sordid act; the other and much the more important is surely this, "See to it that the hire is worthy of the labourer," in the form of the higher and nobler recompense of dignity and self-respect.

#### Phthisis at Bordeaux.

THE town of Bordeaux has instituted an excellent method of practically dealing with the cases of tuberculosis within its boundaries. An Anti-Tuberculous Society has been formed that publishes documents relating to tuberculosis, encourages the use of tuberculin in the stables from which milk is supplied, assists the doctors by analysing and reporting on sputum or other specimens in suspected cases; when necessary, carries out inoculation experiments in guinea-pigs for the purposes of diagnosis, and in every other way possible furnishes aid to the physicians concerned. We are glad to hear that the latest reports speak in the highest terms of the success of this very sensible means of combating the ravages of phthisis.

#### The Proposed Cancer Congress.

WITH a great many people the panacea for ignorance in any subject is a congress, or at any rate a commission of inquiry. They attribute to these bodies sundry occult powers of discovering the truth, and, having voted in favour thereof, they fold their hands in the blissful consciousness of having done something to help the cause. Scientific men on the contrary are disposed to question the gain to knowledge of these ever-recurring congresses. It is difficult to define in these days of international journalism the way in which these gatherings can advance our knowledge of the subjects under discussion. If anything new or interesting crops up which is quite exceptional, it simply means that a particular investigator has held over his communication in view of the meeting. Truths are not elucidated in view of a congress, and failing such a meeting they would be communicated to the scientific world by the ordinary channels, which, after all, are better suited to the purpose. Of all subjects in the world in respect of which a congress would be futile and indeed absurd, cancer is the least amenable to discussion. What we require is fact not discussion, and facts are being

strenuously sought after by hundreds of trained intelligences throughout the civilised world. No stimulus is needed in the way of prizes or rewards, the privilege of having been able to throw light on this dark corner in pathology would be, in itself, ample compensation for a lifetime devoted to laborious research. The endowment of research is another matter. The labourer cannot give the measure of his skill without the proper tools, and men who devote their time and energy to unremunerative pursuits must be provided with the means of subsistence.

#### Resuscitation in Chloroform Narcosis.

ANY amateur anæsthetist who has been suddenly called upon to "do something" in an alarming case of chloroform narcosis must wonder how it was that he could think of so few measures when so many have been suggested. Some of them, quoting from a recent article by Dr. A. Wilson in the *New York Medical Chronicle*, might not occur to the average practitioner. We note, for instance, the application of Corrigan's button to the epigastrium, dilatation of the sphincter ani, or the application of a hot sponge to the perinæum. Should none of these occur to the person in charge of the case he may stimulate the heart by intermittent pressure, rapid percussion, faradisation, or acupuncture. Failing the presence of mind to carry out all or any of these restorative procedures the belated physician may advantageously administer, subcutaneously or by inhalation, always supposing that the patient will breathe for the purpose, drugs which have the power of stimulating the depressed nerve centres—ammonia, nicotine, strychnine, extract of suprarenal capsules, "and the like." It is hardly conceivable that he should be unprovided with these everyday drugs, or that he should forget or omit to make use of them. Seriously, however, of all the measures suggested for the resuscitation of the apparently narcotised, the only ones likely to prove of instant avail are the head-low position, artificial respiration aided by rhythmical traction on the tongue, and percussion over the cardiac area.

#### Popular Theories of Tuberculosis Prevention.

FOR the time being the daily newspapers contain many "letters from correspondents" desirous of airing their views of how to prevent the spread of phthisis. In ninety-nine cases out of a hundred their arguments are rendered worthless by some plan that would be evident to anyone possessing a modicum of medical training. This persistent effort to solve problems that have hitherto defied the most advanced medical skill is not without its underlying moral. It shows, for one thing, how the average man prefers to trust his own judgment in matters of medicine, notwithstanding the particular point on which he elects to give his decision involves a knowledge of facts in prevention, causation, and treatment of an insidious malady, to say nothing of a close acquaintance with pathology, bacteriology, chemistry,

and other subsidiary branches of medicine. In many cases the intelligent layman not only feels himself capable of cutting the Gordian knot, but also of deciding which quack remedy of unknown composition he will purchase by way of cure. Instances of this species of misguided sagacity on the part of *the man* in the street are "plenty as blackberries" (*sic*). Last week a London daily newspaper contained the sapient suggestion that all tuberculous sputum could be rendered harmless if pellets of creosote and eucalyptus were kept in the patient's mouth. In other words, he would trust the destruction of the myriads of bacilli buried in the sputum to their momentary exposure in the mouth to a feeble disinfectant surface. Some day it is to be hoped that the newspapers generally will be educated in the rudiments of preventive medical science.

#### Malaria and House Sanitation.

THE ancient sanitary maxim which directs every man to "keep his house in order" has received a fresh and striking illustration in the case of malaria. In an interesting letter addressed to the Honorary Secretary of the Liverpool School of Medicine, Major Ronald Ross has described the steps taken to rid Freetown, Sierra Leone, of the mosquitoes that carry malaria. The main attack has been naturally directed against the pools of water in the district, for those sites, as most folk know nowadays, are the natural breeding places of the pestiferous insects in question. A most important additional portion of Major Ross' work, however, has been devoted to the houses of the town. He has organised a gang of seven men, who are constantly engaged in destroying mosquito larvæ in private houses, and in carrying away tin cans, broken bottles, old buckets, and other receptacles in which these dangerous little midges breed. They clear about forty houses daily, and carry off in that way some ten cartloads of pots, of which about one-third formerly bred mosquitoes. This pen and ink sketch presents a most instructive object lesson of practical sanitation founded upon advanced scientific discovery. It emphasises afresh the old observation that tropical disease is often favoured by the bad sanitary environment of the dwelling-house. A few years ago the average intelligent European would have laughed the laugh of the scornful had one told him he was fostering malaria by throwing his empty pickle bottles and meat cans on the domestic dust heap. Yet nowadays science has demonstrated the relationship of those apparently absolutely diverse facts.

#### The Housing of the Poor.

MR. FLOWER, one of the speakers in the recent debate in the Commons upon the Local Government Board vote, appears to entertain an exalted idea of the capabilities of that Department. He suggested that the Board should instruct the local authorities in the building of houses for the very poorest at such a cost that the rentals would come within the means of the class for whom the houses were intended. His theory of the relations that should

exist between the central and local administrations in this important particular is almost ideal. Unfortunately, in attempting to reduce his views to practice he would find himself faced with some very hard nuts to crack. Many experiments have been made by public bodies in various parts of the United Kingdom to erect cheap artisans' dwellings. Hitherto, however, the plainest buildings and the cheapest materials have cost so much that it has been found impossible by means of a small rent to pay interest on capital and repay original capital by a sinking fund. The only two factors that are really capable of reduction are the extension of the time for repayment of prime expenditure and the high price of land. To deal with those underlying causes is clearly in the hands of Parliament, and not of local governing bodies. The attention of Mr. Flower may be drawn to these elementary considerations, in order that he may consider the advisability of going to the fountain head for his most desirable reform. It is, of course, within the bounds of possibility that he may have evolved some practical solution of the housing problem. In that case his scheme would be of advantage to the Local Government Board, which cannot be expected to play the part of blind leader to blind local bodies.

**The President's Address at the British Pharmaceutical Conference.**

As might have been expected, the President's Address at the Dublin meeting dealt with the advance of sciences collateral to pharmacy during the century. To do any justice to the address in an article is impossible, for to get an idea of its great range of subject, its fulness of information, and the learned orator's mastery of his subject, the address must be read. The first thing that strikes the reader is the fulness of details and their natural arrangement, fact follows fact naturally and smoothly, so that the reader glides along a century's history without one jarring note. Passing over the earlier passages we come to his story of the progress of dentistry, in which good work British workers bore no small part. Davy, Dacton, Crookes, Ramsay, Dewar, Kelvin, Brown, figure as fellow-workers in the world of science, with Reozelius, Meyer, Mendcalf, Pasteur, Coventon, Pelletier, and others. In this connection we are sorry that Kane, O'Donovan, and O'Shaughnessy are not mentioned. Kane was, perhaps, the very first to demonstrate that the hydrogen of ammonia was displaceable, O'Donovan's papers on aloes were among the first detailed accounts of the analytical searches for alkaloids, and O'Shaughnessy's researches on Indian drugs have a permanent value. Dewar's experiments unfortunately failed to recall those of Andrews on the allotropic forms of oxygen. We merely mention these; in no carping criticism do we judge of the brilliant address. To Liebeg he ascribes the discovery of chloroform. We are inclined to think that the discovery was due to Washington's friend, Mr. Samuel Guthrie, chemist, to the Army of Independence. It is, however, merely a question of priority, for the anæsthetic was inde-

pendently discovered by Guthrie, Liebeg, and Soubeiran. Botany claimed a large share of the President's attention, and he pays a well deserved compliment to Dr. D. Moore's "Cybele Hibernica," which has done so much for Irish flour. He refers, among others, to Bentley and Trimen's praiseworthy "Medicinal Plants," and yet we regret there is no reference to Dr. William Woodville's "Medical Botany," though it was published as early as 1790. Yet it for beauty of illustration and accuracy of delineation still remains *facile princeps*. The more modern study of bacteriology in its early history, its present development, and its fascinating story, for the speaker has the gift of clothing the dry bones and giving them form, life, and beauty, so that the fascination of genius robs the brain of weariness, and as subject follows subject the listener feels no fatigue, and his receptivity of the story of scientific progress remains undulled. The address is a great one, worthy of the man and of the occasion.

**Increase of Lunacy in the Yorkshire District.**

THE increase of lunacy is unfortunately being reverted to much too often in our columns, and for reasons which are unavoidable, and which are frequently spoken of. Three main groups of the insane are now and again coming up for notice—paying patients, epileptics, and idiots. No sooner is relief granted in one direction than it is claimed in another. The discussions which arise at the meetings of our Committees on the subject of lunacy and allied social and medical matters, are very interesting, especially when well reported in local newspapers, and useful in furnishing an education of the trend of public opinion on the subject of the value given to these matters. If the camera of the reporter may be really taken as a correct one, we should say that the most clamorous views, *it may be also the coarsest*, are those of the epileptics and the idiots, perhaps because they are most repulsive. One thing is certain, a good deal has yet to be done, however before our duty has been accomplished towards the miserable people who are able to do so little for themselves.

**Modern Casualty-Room Work.**

NOWADAYS the work of the hospital casualty-room has become more or less modified in accordance with the trend of modern aseptic surgery. Personal cleanliness is rightly regarded as a matter of first importance among dressers and house surgeons; thus, the dresser is directed to wash and to disinfect his hands before dealing with any injury that either involves operation or presents a breach of skin surface. The patient's skin is most systematically and carefully disinfected. Instruments are boiled from time to time and kept in antiseptic solutions, of which the one in forty carbolic lotion still remains a chief favourite. Sutures are of the non-absorbent and aseptic type, such as catgut, silkworm, gut, and horsehair, kept ready in jars of antiseptic lotion. A handy general dressing is gauze

kept in carbolic lotion and wrung out before use. Burns are cleansed with boracic in preference to carbolic lotion, as the latter is painful and liable to absorption. Boracic acid lotion is also used almost exclusively for the eye and face. The ointments in vogue are chiefly boracic acid, yellow oxide of mercury, and eucalyptus and vaseline, or other antiseptic unguents. Large quantities of boracic acid powder and iodoform are applied to wounds, while bruises are treated with glycerine and belladonna on lint. Poultices have been entirely superseded by light antiseptic fomentations applied under oiled silk. The results of modern casualty-room work are most encouraging, as rapid healing is the rule, and septic complications are extremely rare.

#### Disinfection after Cancer.

THE recent public allusion of the King to cancer and its possible prevention cannot fail to attract widespread attention to the subject. Indeed, it appears to have already roused the energies of the Eton Rural District Council, as testified in their proceedings last week. One of the members went so far as to ask the Medical Officer of Health if he disinfected after cancer. The official in question replied that in a report he was preparing on cancer he proposed to recommend that houses should be cleansed properly at his discretion. This proposal, it need hardly be remarked, registers an extremely high standard of preventive health administration. Indeed it may almost be regarded, in the absence of absolute proof as to the infectiveness of cancer, as somewhat transcendental in character. On the other hand, the Eton Rural Council may be asked whether they have adopted systematic disinfection in tuberculous disease which is known to be due to a specific bacillus. Then, again, there are the familiar scourges of measles and whooping-cough, which probably kill a far greater number than cancer of the inhabitants of the twenty parishes that make up the Eton rural jurisdiction. Perhaps one day the prevention of the two humbler maladies may become fashionable, and the desirability of disinfection after their occurrence be more widely recognised by the local authorities of the United Kingdom.

#### Save me from my Friends!

SOME ill-advised person has written a letter to *The Times*, to which it is to be regretted that the editor gave publicity, complaining that a paper by Dr. Maguire, of the Brompton Hospital, was "relegated to an obscure position" at the Congress on Tuberculosis, and virtually ignored. The writer signs himself "A Layman," and with a truly layman's confidence he claims that the treatment by Dr. Maguire's method has produced marvellous results in cases "regarded as hopeless," and he is correspondingly indignant at "this virtual suppression." We feel sure that no one deplors this tactless effusion more than Dr. Maguire himself, the more so as any suggestion of his, supported by encouraging results, would certainly receive respectful attention at the hands of his brethren.

#### A Judicious Forecast.

THE London correspondent of the *New York Medical News* may be congratulated upon the possession of an unusual degree of perspicacity. In the issue for July 13th he observed, in reference to Professor Koch: "It may be said of him, as it was said of Dupuytren, that his motto might be '*Faire autrement*.' He has, as far as so godlike a man can share in human weakness, the instinct of sensationalism, and from the somewhat mysterious foreshadowing of the lines of his address which he has communicated to the officials, one may gather that he intends to say something that will startle the Congress." This the Professor has certainly done, not altogether to the satisfaction of the scientific world, many members of which have reached an age at which sudden and violent emotions are disagreeable and even dangerous.

#### First Egyptian Congress of Medicine.

WE are asked to announce that the first Egyptian Congress of Medicine will be held at Cairo between December 10th and 14th, 1902, under the patronage of His Highness the Khedive and the Government of Egypt. Contributions are invited more particularly on diseases peculiar to that country, such as bilharzia, ankylostoma, bilious fever, hepatic abscess, &c. Epidemiology will necessarily afford an important subject of discussion. The complete programme will be published later, when particulars will be given of facilities of travel accorded by the various companies.

#### The X-Rays and Malingering.

AN unfortunate man who has been obliged to undergo the anxiety and suspense of three trials spread over the period of thirty-six months for what is in Russia the criminal offence of malingering has at last succeeded in convincing the authorities that he is not the arch impostor it was sought to prove. The man came under examination as an Army recruit and was found to exhibit a swollen left ankle and foot. He said he had received a blow from a heavy weight upon the foot. The military surgeons accused him of malingering, and averred that the œdema had been induced by bandaging. At two different trials he was sentenced to imprisonment, but at the third trial a skiagram proved that there had been a fracture from the blow affecting the tarsal arch, and injuring the circulation in the part concerned. An earlier resort to such a very obvious diagnostic method would have spared the wretched patient many months of misery.

#### PERSONAL.

MR. THOMAS JOHN CARSON, L.F.P.S. and L.M. Glasg. has been placed on the Commission of the Peace to the Borough of Oldham.

PROF. W. E. SMITH has resigned the post of Medical Officer to the London School Board which he has held for the past twelve years.

THE King has been pleased to appoint Dr. William Hoffmeister and Dr. Edgar Hoffmeister medical attendants to the Royal establishment at Osborne.

THE death is announced of Dr. Widerhofer, the Austrian Court physician, whose name is perhaps best known in connection with the tragic death of the late Crown Prince Rudolf.

THE Gilfillan prize has been gained by a lady for the first time, and was awarded last week at the Edinburgh University Graduation Ceremony to Miss Agnes Moore Hamilton, M.B., B.Ch. A full list of prize winners and gold medalists will be found in another column.

THE Chesterfield Medal for Dermatology, given under certain conditions as the result of a competitive examination at St. John's Hospital for Diseases of the Skin, has this year been awarded to George Norman Meachen, M.B., B.S.Lond., M.E.C.P.Edin., M.E.C.S., Clinical Assistant to the Hospital for Diseases of the Skin, Blackfriars.

SURGEON-MAJOR-GENERAL W. A. THOMSON, M.B., Hon. Phys. to the King, has been selected for a Good Service Pension. It is nearly fifty years since this officer received his first Commission as an Army Surgeon. He has served in many parts of the world, and at the time of his retirement in 1892 he was Principal Medical Officer in India.

## The British Medical Association.

### ANNUAL MEETING HELD AT CHELTENHAM,

JULY 30TH TO AUGUST 3RD, 1901.

Few pleasanter or more suitable places for the meeting of a Congress whose votaries seek to combine work and pleasure could be found than Cheltenham. A fair town, situated in the midst of lovely surroundings, it has, in the first place, the charm of historic associations. Here rank and beauty have foregathered. Beau Brummel walked its streets, crowned heads have drunk its waters. Nor can the medical profession ever forget that one of the greatest of its members here led a humble and useful life—Edward Jenner. The British Medical Association met here once before, and it is a coincidence of special interest, as the Mayor of Cheltenham remarked when welcoming us to the town, that as this meeting takes place in the year of the accession of our gracious King Edward VII., so the last meeting was in the year of accession of his illustrious predecessor, Victoria, the great and good. Then the Association was in its infancy, and its members barely reached four figures; now with a membership of nearly 19,000, its branches are found all over the British Empire, and it has become a power in the land. The inaugural meeting derived a special interest from the presence of delegates from nearly all parts of the British possessions; and as they stepped up on to the platform to shake hands with the President, they were loudly cheered. Of the President, Dr. G. B. Ferguson, we may say that seldom has a more genial, eloquent, or learned President occupied the chair; and his masterly address will live in the memory of probably every one of the large gathering privileged to hear it.

The Mayor and Mayoress of Cheltenham deserve a special word of tribute to the hospitality which they showed, and in which they were cordially supported by the Town Council. They accepted the visit of the Association as an honour, and in so doing conferred an honour on their guests.

#### ENTERTAINMENTS.

These began with a largely-attended "At Home" on Monday evening at the Winter Garden, where the Annual Museum and Exhibition were held. The opening cere-

mony was performed by the Mayor and Mayoress. On Tuesday, at 11.30, the annual sermon was preached in St. Matthew's church by the Very Rev. the Dean of Gloucester (Dean Spence), who took as his text, "Luke, the beloved physician" (Coloss. iv., 14). In the afternoon, after the first General Meeting, a garden party was given at Battledown Court by Col. Rogers, J.P., and Mrs. Rogers. In the evening the President's address was deemed to supply the place of entertainment, and it proved, indeed, most enjoyable.

On Wednesday, after the second general meeting, the Mayor and Mayoress gave a garden party in the lovely grounds of Pittville Park; the element of music on this as on other occasions throughout the Congress being supplied by Herr Wurm's excellent White Viennese Band. In the evening Dr. J. F. Goodhart delivered the address in medicine; and after this the Mayor and Mayoress again acted as host and hostess at an illuminated fête in the Montpellier Gardens. On Thursday the third general meeting was held, and besides the delivery of the address in surgery by Sir William Thomson, C.B., it derived a special interest from the presentation of the Stewart Prize to Dr. Patrick Manson, C.B. Three garden parties then simultaneously followed:—Lieut.-Col. and Mrs. Griffith were At Home at Deanwood; Mr. and Mrs. MacKnight-Crauford at Fullwood Park; and Alderman and Mrs. T. B. Winterbotham at Cranley Lodge.

Thursday evening was devoted to the annual dinner of the association in the beautiful hall of the Boys' College at Cheltenham. Some account of this will be found in another column. After the dinner a ladies' reception was held at the same place. On Friday afternoon an excursion to Gloucester had been arranged, and in the evening a brilliant soirée was held at the Ladies' College, followed by dancing. An excursion to the Wye Valley brought a very delightful week to a close.

#### THE SECTIONS.

The work of the meeting was universally voted, by those qualified to speak, as being fully up to the standard of the best traditions of the Association. Full meetings were the order of the day, although none of the rooms allotted for the purpose were particularly large. The section of obstetrics and gynaecology was, as usual, well patronised, this being one of the branches that appeals most largely to the general practitioner as well as to the specialist. A pleasing feature of this section was the good attendance of lady members, who joined freely in the discussions, and whose remarks were always well received. Nothing of startling interest in the way of new theories or discoveries characterised the proceedings of the sections, but there was good honest work all round. It would be impossible to give here even a summary of the papers and discussions. Many of them were valuable, and will serve as landmarks for future reference. The columns of our contemporary, the *British Medical Journal*, will be well filled with them for some time to come, and to its pages we must refer our readers for the bulk of the matter. We are able to present abstracts of a few of these papers in our columns.

#### THE EXCURSIONS.

On Tuesday, Thursday, and Friday afternoons arrangements were made for trips to Cleve Hill by electric cars. On Tuesday there was an excursion to Tewkesbury, where tea was partaken of at the Bell Inn ("John Halifax's" house); the Vicar of Tewkesbury met the members at tea, and afterwards conducted them over Tewkesbury Abbey. Chedworth and Withington were visited on Thursday, and after a visit to the Roman Villa, Mr. T. L. Robertson entertained the members to tea at Withington Manor. On Friday a trip was made to Birdlip, where the party drove through Cranham Woods, whilst some proceeded to Painswick, where Dr. Balfour Fergusson received them to tea. Among the larger excursions we must first mention the one to Gloucester on Friday. One section went to the Guildhall, where Mr. Bellows gave a short address on "The Place of Gloucester in the Roman History of Great Britain" this was followed by a walk through the city, where Mr. Bellows showed the chief points of interest. Another section proceeded to Barnwood House, where

the Committee of Governors and Dr. and Mrs. Soutar received them at a garden party; a feature of this was the performance of a pastoral play, "Twelfth Night," by Ben Greet's company. A third section went by a later train, and assisted at an "At Home" in the Guildhall, given by Dr. and Miss Batten. During the afternoon the town clerk exhibited some of the city charters and other interesting records belonging to the city; and the very Rev. the Dean of Gloucester accompanied the members over the Cathedral, and gave them a short *résumé* of its history and architecture. On Saturday there was an excursion to the Wye Valley and Symond's Yat. Detraining at Lydbrook Junction, the party walked over the Coldwell Rocks to Symond's Yat, a distance of three miles, the less energetic members doing this part of the journey by train. After lunch boats were chartered at the Yat to convey the members to Monmouth, whence they proceeded to Tintern and inspected the abbey, after tea at the Beaufort Arms Hotel.

Another excursion on the same day was to Cirencester; after partaking of refreshments at the kind invitation of Mr. Oliver Fowler, at Ashcroft House, the party continued in brakes to Earl Bathurst's park, proceeding thence to Sapperton to view the Golden Valley and inspect the church. Tea was served at Cripps' Mead, by kind invitation of Mr. Wilfred Cripps, C.B., and Mrs. Cripps (Countess Bismarck). Two other excursions were also planned, to Great Malvern and Cowley Manor respectively.

#### THE RECONSTRUCTION OF THE ASSOCIATION.

There is no doubt that a large number of members of the Association were drawn to Cheltenham by their interest in the proposed new scheme of reconstruction. It must be gratifying to those who for twelve months have anxiously and laboriously consulted together in the drawing up of the scheme that it was adopted practically in its entirety. The main principles of the scheme were accepted with very little demur, and only very slight alterations in details were either proposed or carried out. Perhaps the most closely contested point was that which referred to the option of members of Council, and some of those who objected most strongly to the principle nearly succeeded in securing its alteration; but the amendment was lost by three votes. There is no doubt that the acceptance of the scheme by the members present at the meetings was in large measure due to the masterly, eloquent, and diplomatic speech of Mr. Edmund Owen, ably supported by Dr. Whitaker and Mr. Victor Horsley. It is gratifying that, considering the importance of the issues at stake, there was remarkably little indulgence in those personalities which have formed a somewhat regrettable feature of some of these meetings; and except for one little incident, in which two former antagonists crossed swords, with perhaps more amusement to the onlookers than serious harm to any one, the whole affair passed off smoothly. It would be premature to forecast the result of these decisions on the future of the Association; but no doubt the principle of delegation must introduce a radical change in the course of time.

#### THE ANNUAL MUSEUM.

Owing, no doubt, in great measure to the energy of the Chairman and Secretary of the Museum and Exhibition Sub-Committee, Dr. H. Bramwell and Mr. G. A. Peake, there was a very good show at the Cheltenham meeting; indeed, we have it on the authority of the President of the Association that this year's annual exhibit was a record one. One factor that made for success was the fact that the exhibition was well housed, and it appeared to be pretty freely patronised. Judging from the numbers of names put down in the exhibitors' notebook, there will be a vast consignment of samples in early course of distribution. Space will not allow anything like a comprehensive survey of the exhibits, and we must be content with mentioning a few of the more novel and interesting objects. Ferris and Co., of Bristol, showed a handsome, compact, and well-filled dispensing cabinet; some convenient vaccination pads and leaves; their universal elastic bandages; and especially their newly-introduced plugging gauze, with the introducer

for the same. The last is a neat and ingenious instrument. The Bath Corporation had a well-made model of the Roman Therms at Bath. Cheltine Foods, Limited, showed their diabetic, dyspeptic, anæmic, invalid and infants' foods, put up in tins and made up in bread and biscuits. Our old friend, Scott's Emulsion, was in evidence, and evidently its popularity is not on the wane. Among Burgoyne, Burbidge and Co.'s specialities we noted a new anæsthetic, acoin, reported to be superior to cocaine in being non-toxic and in giving longer anæsthesia. Frank Rogers showed sprays and atomisers. E. Merck had an imposing array of pharmaceutical products with names of many syllables; among the newest we may note bromopin (an organic substitute for bromides), digitoxin, dionin (a mild, pleasant substitute for morphia), iodopin, jequiritol, and largin (an anti-gonorrhœic). Keen, Robinson, and Co. showed their standard preparations. Among the Vichy waters was a new variety, "Celestins," recommended for kidney disorders. Bovril, Limited, showed their foods, including their special emergency foods for military and other expeditions. Marvis, a dry preparation of fresh fish, was an instance of the growing development of the plan of producing permanent and compact forms of food-stuffs. The Liebig Extract of Meat Co. showed a new meat beverage, Oxo. The Apollinaris Co. had their well-known aerated waters on view. Mellin's Food, Limited, showed among other things a new Mellin's food chocolate. Among concentrate proteid products we noted Casumen and Plasmon; the latter has been mixed in a very palatable form with cocoa. John Weiss and Son had a large selection of instruments, and Down Brothers showed, in addition to instruments, a selection of the newest designs in operating tables. The preparations of red bone marrow, known as Virol, were on view. Stephen Smith and Co. showed their Hall's Wine, Keystone Beef Wine, and Keystone Burgundy; and Brand and Co. showed a number of their well-known products. Somatose was another of the concentrated food-products on view. Parke, Davis, and Co. had several new preparations, such as Adrenalin, an alkaloid derived from the suprarenal bodies; Chloretone, a hypnotic, antiseptic and local anæsthetic; Mercuriol, an antiseptic consisting of mercury and nuclein in chemical combination; Ferrinol, a similar combination of iron and nuclein; and also a nuclein solution. Another important exhibit of high-class pharmaceutical products was that of Bayer and Co. Cadbury Bros. had a cocoa exhibit, where weary sight-seers might be observed recuperating. The enterprising Sanitas Co. showed a number of their preparations, including some of the latest products of Mr. Kingzett's ingenuity, among which we specially noticed Kingzett's Sulphur Fumigating Candles, Kingzett's Sulphugators, consisting of rolls or bandages coated with sulphur; Okol, a new non-poisonous disinfectant said to surpass carbolic acid in its antiseptic and germicidal properties; Kingzett's Formic Sulphugators, an ingenious arrangement for generating sulphurous acid gas and formic aldehyde; and Formitas, which combines the properties of Sanitas and formic aldehyde. Among the newer preparations of Fairchild Bros. and Foester may be noted Enzymol and Diazyme, besides older preparations like Panopepton and Peptogenic Milk Powder. The Shredded Wheat Co. showed the various uses to which shredded wheat could be applied in making nourishing dishes. Harry W. Cox, Limited, had some of their newest apparatus for X-ray work. The Abbey Effervescent Salt Co. showed their special and now well-known preparation. Cosenza and Co. exhibited solidified soups; and the Manhu Co., Limited, showed diabetic foods. Nestlé's Milk was, of course, already familiar; a new form was, however, on view—namely, Nestlé's Viking Milk, which is an unsweetened form. An ingenious bed-rest arrangement was shown by the Automatic Bed-rest Co., of Leamington. Defries and Sons had a selection of filters; and the Sanitary and Economic Association showed some of Dr. Bond's inventions, such as the Euthermic quilt, the floating filter, and the Gelidum ice-store and refrigerator. Allen and Hanburys showed a new Clover's ether inhaler, a new inhaler for use with kylene, a new three-way stopcock for use with gas and ether, a new apparatus for preparing small



quantities of distilled water, and many things besides; while Oppenheimer, Son and Co., among their various well-known preparations, showed a new aeriser, for use with their neboline compounds, and a "universal vapouriser." The Maltine Co. showed the numerous forms in which maltine can be combined with other remedial agents. But we must perforce come to an end, and those who wish for more detailed information will find much of interest in the ample catalogue of 120 pages published by the Exhibition Committee. There can be no doubt about the interest and information to be derived from a visit to such a collection of the books, appliances, drugs and foods which form such an important item in medical and surgical practice.

#### THE ANNUAL DINNER.

The annual dinner of the Association was held on Thursday evening at the Boys' College, when some 350 members and guests sat down. The President was supported, among others, by the Mayor of Cheltenham, the High Sheriff of Gloucestershire, the ex President, Dr. Elliston, the President-elect, Mr. Walter Whitehead, the President of Council, Mr. Roberts Thomson, Sir William Church, Sir William McCormac, Sir Walter Foster, Sir William Broadbent, Sir William Thomson, Sir John Dorington, M.P., Dr. Farquharson, M.P., J. T. Agg-Gardner, Esq., M.P. for the Borough of Cheltenham, Sir John William Moore, Surgeon-General Hamilton, Dr. Parsons, Prof. G. Dook, of Michigan, W. F. Hicks-Beach, Esq., J.P., Professor Fischer, Dr. Darier, Col. Croker-King, Dr. Dawson Williams, Dr. Cholmeley, Lieut.-Col. Griffith, the Town Clerk, Andrew Clark, Esq., Dr. Saundby, Dr. Goodhart, Dr. Ward Cousins, F. F. Leaver, Esq., Howard Marsh, Esq., F. Brandt, Esq., J.P., H. T. Carington, Esq., J.P., Col. Rogers, V.D., C. T. Turnbull, Esq., and Malcolm Morris, Esq. A word of praise must be given to the very artistic menu, which was abundantly adorned with appropriate classical quotations. The usual toast: were duly honoured, but delightful as is post-prandial oratory the organisers should bear in mind that it is possible to have too much of it.

#### THE MEDICO-PSYCHOLOGICAL ASSOCIATION AND IRISH "AUXILIARY ASYLUMS."

It will be remembered by our readers that an attempt is at present being made to compel the Irish Government to sanction the appointment of a layman as head of the proposed Auxiliary Asylum for "chronic harmless lunatics" at Youghal. The importance of preventing such a backward step from being taken will be apparent to everyone who considers the class with which it is intended to people these asylums. We have been given to understand that not alone is a layman to be the head but that the administration of the asylum is to be handed over to a religious order. The Cork Medical and Surgical Association, at a meeting held a couple of weeks ago, passed the following resolution:—"That we, the members of the Cork Medical and Surgical Association learn with extreme regret that it is contemplated to appoint a layman as superintendent to the Youghal Auxiliary Asylum, and that in the interests of humanity we consider a medical man should be appointed, as many of the patients suffer from diseases which at any moment may require prompt and skilled medical treatment to ward off impending death."

At the recent meeting of the Medico-Psychological Association held in Cork, Mr. Graham, medical officer of a Belfast Asylum, read a paper on "Recent Legislation in regard to the Treatment of the Insane in Workhouses." As a result of the discussion which followed, an instruction was sent to the Council to take into consideration the treatment of the insane, as contemplated by the new Local Government Act of Ireland.

On the second day of the meeting the treasurer of the Association, Dr. H. Hayes, said that the Council had taken the matter into consideration that morning, and it had come to the unanimous conclusion to submit to the Association this resolution, in the hope that it would be unanimously adopted:—"It is resolved by the Medico-Psychological Association of Great Britain and Ireland that, having considered the provisions of the Local

Government (Ireland) Act for dealing with the insane, now in workhouses, it views with apprehension any scheme which will permit or favour the aggregation of insane patients requiring institutional treatment, except under skilled resident medical supervision. It is of opinion that all patients in auxiliary asylums should be on the same footing in regard to the Government capitation grant as those in the district asylums." It was considered by the Council that this matter should not, under any circumstances whatever, be considered as a local affair, but as one which affected the Association in all its branches in the United Kingdom, because it was one of the first duties of the Association that it should do its best for the treatment of the insane. It had done its best to forward the most liberal treatment by those who were treated outside under lay care. In all parts of the United Kingdom the single care of patients in homes had been forwarded, especially in Scotland, where there was a large amount of home treatment. There was no reason why the same spirit of liberality should not be accorded to patients in England or Ireland. But it was a quite different matter when it came to the aggregation of cases outside asylums under lay care, as it resulted in neglect, ill-treatment, and other disadvantages, of these patients, who required care and treatment in large institutions with proper medical supervision. They did not for a moment wish that the ideas of mercy and good treatment were in the medical world alone, for they knew that many lay people had the best instincts, and even the most moving resolutions in the matter of the treatment of insanity had come from lay people; but they said that medical supervision was absolutely necessary in caring for large bodies of the insane. Dr. Bolton's paper had shown that there were cases that could easily pass skilled medical attention, and how many more of these cases would escape detection under non-medical supervision. It was the experience of the association that the aggregation of large numbers of patients without proper medical supervision, was a wrong which it was their duty to combat as strenuously as they possibly could. (Hear, hear).

Dr. T. S. Clouston, in seconding the resolution, said he was sure that the gentlemen who brought the matter forward had rendered a service to the insane and to science. (Hear, hear.) He suggested that copies of this resolution be forwarded to every newspaper in Ireland. (Hear, hear.)

Dr. Harvey, Clonmel Asylum, in supporting the motion, said that his committee had come to the conclusion that it would not be for the benefit of the insane to start an auxiliary asylum, and they were giving him three blocks of buildings instead as an extension. (Hear, hear.)

The resolution was agreed to unanimously.

On the motion of Dr. H. Hayes, Newington, seconded by Dr. Urquhart, it was decided to forward copies of the resolution to the Chief Secretary for Ireland, the Inspectors of Lunacy, and others.

We trust that the efforts of the Cork members of the medical profession and of the Medico-Psychological Association will meet with success, and that the gross error which is contemplated will be rendered impossible.

#### A Visit to Bovril, Limited.

On the invitation of Lord Duncannon (the Chairman) and the directors of Bovril, Limited, the members of the British Congress on Tuberculosis visited the laboratories and factory of Bovril, Limited, on Friday and Saturday last. Special interest was manifested in the army rations, samples of which, as supplied to the Nansen, Jackson-Harmsworth, and Wellman Polar Expeditions, were on view. An interesting feature was an exhibit of samples of goods supplied for the Royal Antarctic Expedition, which starts to-day (Wednesday). The process of the manufacture of Virol, the now well-known substitute for cod-liver oil, was shown and explained, and the delegates expressed themselves very pleased with their visit.

#### Death from Poisoning.

An inquest was held on the 28th ult. on the body of Dr. Joseph Wood, of Liversedge, who had succumbed

to an overdose of bromidia taken for the purpose of procuring sleep. A verdict of accidental poisoning was arrived at. The deceased leaves a wife and child.

Apothecaries' Hall of Ireland.

We are requested to announce that at the annual meeting of the General Council of the Apothecaries' Hall of Ireland, the following were duly balloted for and elected to hold office for the ensuing year ending July 31st, 1902. Governor, George A. Stritch, L.F.P.S.G., L.M.; Deputy-Governor, Arthur Atcock, M.D., M.S., E.U.I.

Directors: Hugh A. Auchinleck, F.R.C.S.I., L.R.C.S. Edin.; John Evans, L.R.C.S.I.; William V. Furlong, L.R.C.S.I., L.R.C.P.E.; J. Adam Johns, M.D., T.C.D.; Thomas D. Finucane, M.D.; Edward Hanrahan, M.B., B.U.I.; Robert Montgomery, M.R.C.S.; Robert J. Montgomery, M.B., T.C.D., F.R.C.S.I.; Richard G. O'Flaherty, L.R.C.S., M.B., T.C.D.; James Raverty, L.R.C.S.E.; Joseph A. Ryan, L.R.C.S.E.; James Shaw, L.R.C.S.I.; Charles R. C. Tichborne, L. and D.P.H., R.C.S.I.

Representative General Medical Council: Charles E. C. Tichborne, L. and D.P.H., R.C.S.I.

Secretary: Robert Montgomery, M.R.C.S.

Report of the Annual Meeting of the Medico-Psychological Association of Great Britain and Ireland.

THE sixtieth annual meeting of the Medico-Psychological Association of Great Britain and Ireland was held in the Queen's College, Cork, under the presidency of Dr. Oscar T. Woods, Resident Superintendent of Eglinton Lunatic Asylum, Cork. There were about sixty members present, representing all parts of the kingdom, and a number of important papers were read on various aspects of lunacy. Committees met at 9 a.m., and two hours later the annual meeting began, with the outgoing President, Dr. Fletcher Beach, in the chair. The officers and council were elected unanimously as follows:—President: Oscar T. Woods, M.D. President-Elect: J. Wiglesworth, M.D. Ex-President: Fletcher Beach, M.B. Treasurer: H. Hayes Newington, F.R.C.P.Ed. Editors of Journal: Henry Rayner, M.D.; A. E. Urquhart, M.D.; Conolly Norman, F.R.C.P.I. Auditors: Ernest W. White, M.B.; James M. Moody, M.R.C.S. Divisional Secretaries: South-Eastern Division, A. N. Boycott, M.D.; South-Western Division, P. W. Macdonald, M.D.; Northern and Midland Division, C. K. Hitchcock, M.D.; Scotland, Lewis C. Bruce, M.B.; Ireland, A. D. O'C. Finegan, L.R.C.P.I. General Secretary: Robert Jones, M.D., B.S., F.R.C.S. Registrar: H. A. Benham, M.D. The President (Dr. Oscar T. Woods) who was cordially received, then delivered his presidential address. Dr. John Carswell (Glasgow) read an interesting paper on "The Working of the Inebriates Act," in which he said that this experimental legislation had been a failure. A discussion followed, in which Dr. H. Hayes Newington, of Sussex; Dr. Clouston, Dr. Fletcher Beach, Dr. Urquhart, Dr. Conolly Norman, and Dr. Eustace took part, in which the opinion was generally expressed that the class coming under the Act were mostly incurable, and further legislation was needed to deal with the reclaimable class. Papers were also read by Dr. Thomas Drapes, Superintendent Ennis-corthy Asylum, on "Insanity and Phthisis;" by Dr. F. W. Everige Green, Hatchcroft House, London, on "Evolution of the Colour Sense;" by Dr. E. D. O'Neill, Superintendent Limerick Asylum, on "The Superannuation Question—its Effect on Asylum Officials, with Suggestions for Further Legislation on the Subject;" by Dr. Graham, "Recent Legislation in Regard to Treatment of Insane in Workhouses." The meeting then adjourned. On the second day of the meeting, during the morning, Professors Dixon and Bergin exhibited some excellent radiographs and gave an interesting demonstration of X-ray stereoscopy. Dr. Joseph Shaw Bolton, of Claybury Hall, Essex, contributed a lantern demonstration on "Gross Lesions of the Cerebrum." The Treasurer then submitted the report of the Council on the treatment of the insane as contemplated by the new Local Government Act of Ireland. His remarks will be found in another column. Dr. A. R. Urquhart, Perth, then read a paper on "Effect Upon Patients of Changes of Asylums," and Dr. R. E. Leeper, Resident Physician, St. Patrick's Hospital, Dublin,

contributed a paper entitled "Three Cases of Melancholia: Presenting Symptoms of Unusual Clinical Interest," and he also showed microscopic specimens and photographs. Dr. Dawson also read a paper in which he gave a number of cases in which the drugs suprarenal extract and thyroid extract had given most satisfactory results. A cordial vote of thanks to the President for his services to the Association, and his hospitality to the members brought the meeting to a close.

#### Dublin Death Rate.

THE deaths in the Dublin registration area for the week ending July 27th gives an annual rate of mortality of 21.5 a 1,000. Pulmonary diseases caused 19 deaths. Deaths from tuberculosis were 32, of which 26 were from pulmonary tuberculosis, 3 from abdominal tuberculosis, 2 from tuberculous meningitis, and 1 from peripneumonia. Fifty of the persons who died during the week were under five years of age (36 were infants under one year, of whom 3 were under one month old). Eight children were registered as having died from convulsions; 7 of these were under one year old. How many of them were insured?

#### Irish Medical Schools' and Graduates' Association.

THE summer general meeting of the above association was held in the Ladies' College, Cheltenham, on Wednesday, July 31st. The attendance of members was unusually large, and the chair was occupied by Dr. Mapother, Vice-President. The Council reported that since the annual general meeting the restrictive rule had been repealed in the case of two provincial hospitals. Sir John William Moore (Dublin) said that the subject of the exclusion of those holding the higher diplomas of the Royal College of Physicians of Ireland from candidature for honorary appointments in English hospitals had for several years engaged the anxious attention of the College. After some remarks on the same subject from Professor Thompson (Belfast), the meeting adjourned.

## Pass Lists.

### Edinburgh University Graduation Ceremonial.

AT the summer graduation ceremonial, held last week, the following degrees were presented:—

Degree of Doctor of Medicine: c Robert Oswald Adamson (M.A.), M.B., C.M., with first-class honours, 1889; a Alexander Cruickshank Ainslie (M.A.), M.B., C.M.; John Charles Atkinson, Chiti, M.B., C.M.; a James Martin Beattie (M.A.), M.B., C.M., with first-class honours; c John Macaulay Bowie, M.B., Ch.B.; c Henry Reynolds Brown (M.A.), M.B., C.M.; c Henry Grey Brown, M.B., C.M.; c Robert Nichol Brebner, M.B., Ch.B.; Robert Cathcart Bruce, M.B., C.M.; a Thomas Hastie Bryce (M.A.), M.B., C.M.; Robert Dick Buchanan, M.B., C.M.; Morton Burnet, M.B., C.M.; c Frederick Harold Carlyon, M.B., C.M.; Bernard Ramsay Craig Christie, M.B., C.M.; c Edgar Ferdinand Cyriax, M.B., Ch.B.; Daniel Rees Davies, M.B., C.M.; Walter Dickson, M.B., C.M.; Daniel Charles Edington, M.B., C.M., with second-class honours; b Richard Cogswell Elsworth, M.B., C.M.; David Smart Evans, M.B., C.M.; Gordon William FitzGerald, M.B., C.M.; b Duncan Forbes, M.B., Ch.B., with second-class honours; Thomas Dewar Forbes, M.B., C.M.; a Evan John Hewat Fraser, M.B., C.M., with first-class honours; c Harry Edward Gibbs, M.B., Ch.B. (in absentia); b Alexander Goodall, M.B., Ch.B.; b Thomas Duncan Greenlees, M.B., C.M.; b George Kerr Grimmer (B.A.), M.B., C.M.; Robert Lyall Guthrie (M.A.), M.B., C.M.; b Arthur Cecil Heath, M.B., Ch.B.; Alexander Hendry, M.B., C.M.; b John Thomas Hewatson, M.B., C.M., with second-class honours; c John Hume, M.B., C.M.; b Louis Godfrey Irvine (M.A., B.Sc.), M.B., C.M.; Charles Harold Johnson, M.B., C.M.; William Kinnear (M.A.), M.B., C.M.; William Broad Kirdaly, M.B., C.M.; c Thomas Knowles, M.B., C.M.; a Louis Francis Behagen Knuthsen, M.B., C.M.; c Robert Laidlaw, M.B.; b Gerald Rowley Leighton, M.B., C.M.; b Sreenagula Mallannah, M.B., C.M.; c Thomas Muirhead Martin, M.B., C.M.; George Home Monroe Home, M.B., C.M.; Athelstane Nobbs, M.B., C.M.; David William Horn Paterson, M.B., C.M. c Charles

Edward Potter, M.B., C.M.; b John Vernon Rees Roberts (B.Sc.), M.B., C.M.; b Thomas Arthur Ross, M.B., C.M.; a Alfred Charles Sandstein, M.B., Ch.B. (with first-class honours); a Sutherland Simpson (B.Sc.), M.B., Ch.B.; c Edgar Somerville, M.B., Ch.B.; c Harry Bird Sproat, M.B., Ch.B.; c William Anderson Steven (M.A.), M.B., C.M. (with first-class honours); Gabriel Hendrik Steyn, M.B., C.M.; c George Crowdon Thomas, M.B., C.M.; c William Fookes Thompson, M.B., C.M.; Arthur Harry Hingston Vizard, M.B., C.M.; a Donald Bremner Waters (M.A.), M.B., Ch.B. (with first-class honours); b Andrew Robertson Wilson (M.A.), M.B., C.M. (with first-class honours); Andrew Hamilton Wood, M.B., Ch.B. (a Awarded Gold Medals for their theses. b Highly commended for their theses. c Commended for their theses.)

Degree of Doctor of Science: Alexander Wilmer Duff, M.A., B.Sc.; John Vernon Rees Roberts, M.D., B.Sc.

Degrees of Bachelor of Medicine and Master in Surgery: Manindra Nath Bose, Shaik Dawood, Alfred Thomas Gavin, Paul Eugene Hedwige Giuseppe, John Hally Meikle (M.A., B.Sc.), Wm. Henry Meyer, James Donaldson Sauer, Walter Henry Swaffield, c Harry Moss Traquair, John Wallace, John Owen Williams. (c Indicates that the candidate has passed the examinations with first-class honours.)

Degrees of Bachelor of Medicine and Bachelor of Surgery: David Macrae Aitken (M.A.), John Finlay Allan, Charles Madill Anderson, Robert Vacy Clifford Ash, a Robert Tullis Baillie, James William Barrack, a Alexander Clarke Begg, Raphael Aaron Bellios, John Henry Montgomerie Bell, Vivian Chastel de Boinville, b Richard James Bradley, Edward Seymour Brett, James Brocket, Edward Emslie Brown, Gofina Maude Brown, William Brown, James Brownlee, Robert Wilson Buchanan (M.A., B.Sc.), Henry Buist, b George Cruikshank Burgess, Edward Percy Calder, Kirkland Chapel, Charles Coley Choyce (B.Sc.) Arthur William Stark Christie, Robert Veitch Clark (M.A., B.Sc.), Harry Lechmere Clift, William James Crow, Barbara Martin Cunningham, John Dalgleish, b George Adam Davidson (M.A.), b William Henry Dickinson, a William Elliot Carnegie Dickson (B.Sc.), Thomas George Boswell Dodds, Henry Dodgson, Charles Douglas, James Laing Duncan, William Arthur Duncan, William Inglis Dunn, John Russell Edward, William Eggeling (M.A.), Owen John Evans, John William Falconer (M.A.), b Arthur Marcus Firth (M.A.), Gavin Addie Forrest, Stephen Garvin, James Charles Gilchrist, Ernest Mure Granville, Robert Ashleigh Glegg, Thomas Graham, Roderick McKensie Grant, Arthur Leopold Guernsey, Arthur Rupert Hallam, Agnes Moore Hamilton, Robert Hamilton, William Hamilton, Niels Carl Rudolph Hansen (B.A.), Robert Alexander John Harper, Percival John Hay, Eleanor Russell Henderson, David Colvin Henty, Charles William Howe, a Andrew Hunter (M.A., B.Sc.), Andrew Edwin Hunter, Alexander Rea Johnston (M.A.), George Adam Jolly, Edgar Vaughan Jones, b Andrew Campbell Keay, James Price Kennedy, Percy Vance Langmore, Abdurrahman Khan Lauddie, William Lee, Creighton Hutchinson Lindsay, Samuel Lyle, James Graham M'Bride, Lawson Tait M'Clintock, Hector Kenneth Macdonald, William MacDougall (M.A.), Patrick Frederick M'Farlan, b George M'Farland, Alistair Forbes Mackay, Francis Dillon Scobie Mackenzie, John M'Kenzie, William M'Lachlan, William Mair (M.A., B.Sc.), George William Peak Maitland, Alexander Mowatt Malcolmson, Edward Charles Cecil Maunsell, b George Robertson Mill, Thomas Mill, William Miller, Joseph Miskelly, Alexander Monat, David Munro (M.A.), George Stewart Murray, a Peter Murray (M.A.), William Murray, Elvin Gladstone Osborne Nixon, David Alexander Ogilvie, John Fraser Orr, John Louis Palmer, William Paterson, Walter Scott Patton, John George Peebles, Sidney George Peill, George Pereira, Howard George Pesel, Laurence William Pole, Edmund Thurlow Posts, b William Hogg Prentice (M.A.), Lloyd Turton Price, Henry St. John Randell, Francis Lindsay Rigby, Hugh Moreton Roberts, b George Cook Irvine Robertson (M.A.), John Keith Alexander Robertson, Michael

William Robertson, William Arthur Robinson (B.A., B.Sc.), Andrew Lindsay Roxburgh, Laurence Rundall, a Caleb Williams Saleeby, b Thomas Brown Shaw, Margaret Merry Smith, Thomas Aubrey Smyth, Kate Southon, Henry Langlands Spark, William Clark Speirs, Basil Alexander Spence, Arthur Julian de Spiganovicz, Charles Stanley Stevenson, Mand Muriel Stevenson, Donald Alexander Stewart (M.A.), Ian Struthers Stewart, John Sullivan, Matthew Arnold Swan, Paul Telles, George Lewis Thompson, Thomas Lauder Thompson, John Burnett Thorburn, William Leigh Trafford, Edward James Tyrrell, Abraham Ransome Wallis, Edwin Wells, a Thomas Samuel Beauchamp Williams, Frederick Ernest Wilson, James Woods, David Young. (a Indicates that the candidate has passed the examination with first-class honours. b Indicates that the candidate has passed the examination with second-class honours.)

Special University Certificate in Diseases of Tropical Climates.—Shaik Dawood, M.B., C.M., Charles William Howe, M.B., Ch.B., William Miller, M.B., Ch.B.

Thesis Gold Medallists.—James Martin Beattie, M.D., Thomas Hastie Bryce, M.D., Evan John Hewat Fraser, M.D., Alfred Charles Sandstein, M.D., Sutherland Simpson, M.D., Donald Bremner Waters, M.D.

The Syme Surgical Fellowship has been awarded to Alfred Charles Sandstein, M.D., Ch.B.

The Goodsire Memorial Fellowship has been awarded to Sutherland Simpson, B.Sc., M.D., Ch.B.

The Gunning Victoria Jubilee Prize in Anatomy has been awarded to Duncan Forbes, M.D., Ch.B.

The Gunning Victoria Jubilee Prize in Forensic Medicine and Public Health has been awarded to Charles James Lewis, D.Sc., M.D., C.M.

The Ellis Prize in Physiology has been awarded to Sutherland Simpson, B.Sc., M.D., Ch.B.

The Milner Fothergill Medal in Therapeutics has been awarded to Ernest Francis Bashford, M.B., Ch.B.

The Ettles Scholarship has been awarded to Caleb Williams Saleeby, M.B., Ch.B.

The Beaney Prize in Anatomy and Surgery has been awarded to Harry Moss Traquair, M.B., C.M.

The Buchanan Scholarship in Gynecology has been awarded to William Hogg Prentice, M.A., M.B., Ch.B.

The James Scott Scholarship in Midwifery has been awarded to Caleb Williams Saleeby, M.B., Ch.B.

The Allan Fellowship in Clinical Medicine and Clinical Surgery has been awarded to Thomas Brown Shaw, M.B., Ch.B.

The Monat Scholarship in Practice of Physic has been awarded to James Brownlee, M.B., Ch.B.

The Stark Scholarship in Clinical Medicine has been awarded to William Elliot Carnegie Dickson, B.Sc., M.B., Ch.B.

The Murchison Memorial Scholarship in Clinical Medicine has been awarded to Robert Veitch Clark, M.A., M.B., Ch.B.

The Pattison Prize in Clinical Surgery has been awarded to John Saffley.

The Gilfillan Memorial Prize has been awarded to Agnes Moore Hamilton, M.B., Ch.B.

The Cameron Prize in Therapeutics has been awarded to Patrick Manson, C.M.G., M.D., for his researches on the transmission of diseases through the mosquito.

Royal College of Surgeons, Edinburgh.

The following gentlemen having passed the requisite examinations were, at a meeting of the College, held on July 30th, elected ordinary Fellows: George Alexander, M.B., Ch.B., William H. G. Aspland, M.B.C.S.Eng., L.R.C.P.Lond., Alexander Girvan, M.B., C.M., Patrick Kinmont, M.B., Ch.B., William T. McArthur, L.R.C.S.E., Angus Macdonald, M.B., C.M., Stuart A. Ord-Mackenzie, M.B.C.S.Eng., L.R.C.P.Lond., Arthur Davies Peill, M.B., C.M., George H. Pooley, L.S.A.Lond., Matthew A. Reid, M.B., C.M., Edward Robertson, L.R.C.S.E., Frederic H. Sturdee, M.B.C.S.Eng., L.R.C.P.Lond., and George F. Vincent, L.R.C.S.E.

## Notices to Correspondents, Short Letters, &c.

✉ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the publisher or printer before the type has been distributed. This should be done when returning corrected proofs.

ORIGINAL ARTICLES or LETTERS intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

READING CASES.—Cloth board cases, gilt lettered, containing twenty-six strings for holding the numbers of THE MEDICAL PRESS AND CIRCULAR, may now be had at the office of this journal, price 2s. 6d. These cases will be found very useful to keep each weekly number intact, clean, and flat after it has passed through the post.

### JULIUS ROBERT VON MAYER.

The Association of German Engineers have just placed a memorial tablet on the house in Heilbronn in which J. R. von Mayer was born. He studied medicine at Tübingen, Munich, and Paris, and commenced the practice of his profession as a ship's surgeon, and settled as a general practitioner in his native town in 1840. In 1842 he published in Liebig's *Annalen* a preliminary statement of the mechanical theory of heat, in which he clearly demonstrated the numerical relation between heat and work. Seven years before his death he was awarded the Copley medal of the Royal Society, London; in 1876 he was ennobled by the King of Württemberg. He died on March 20th, 1878.

It is peculiarly gratifying to us to see the memory of deserving members of the medical profession duly recognised, and we in no way withhold our own praise; but we cannot help thinking of Dr. Beade, of Cork, whose house bears no memorial tablet, although, in 1808 (34 years previously), he made the discovery, performed the experiment, and announced the law for which, to-day, a German, Mayer, is so honoured.

DR. S. Y. B.—It is doubtful whether pennyroyal, in medicinal doses, has an effect on the pregnant uterus; nor has errot, in spite of the affirmation of medicologists, any abortifacient action, except possibly in the later stages of gestation. The subject is one which urgently calls for further careful study, though the law takes cognisance more of the intent than of the actual effects.

X. R.—Your observation is defective in that the diagnosis does not appear to be placed beyond question. It is obvious that any shortcoming in this respect must invalidate your conclusions, and for this reason we do not think it wise to publish it.

### SHOCKING!

The newspapers state that one of the internes in a Brooklyn hospital is under discipline for having kissed, or rather for having been caught kissing, one of the young and comely members of the training school. We trust such practices will not spread from the new world to the old!

VULNERABLE PARTS OF THE HUMAN ANATOMY.—The murderers have discovered some astonishingly vulnerable parts of the human anatomy of late. From a paper this morning we learn that a Georgia colonel was "shot in the ticket office"; the other day a man was fatally shot "through his door," and not long ago another received a fatal wound "in his window."—*New York Commercial Advertiser*.

MR. JAMES BLAIR.—We are unable to trace the allusion to iodobenzoyl iodide of ammonium in the treatment of broncho-pneumonia. You might apply to Merck, of Darmstadt, or his London agent.

DR. E.—We are not particularly interested in the subject you have chosen for your communication, and the list is at your disposal.

MR. S. M.—Pressure on our space obliges us to hold over your paper for the present. We hope, however, to publish it ere long.

DR. SINGLAIR.—Your letter received too late for insertion in this issue.

## Appointments.

- BELFRAGE, SYDNEY H., M.B., L.R.C.P.Lond., M.R.C.S.Eng., Assistant Anaesthetist to the Dental Hospital of London.  
 BERRYMAN, EDMUND N., L.R.C.P.Lond., M.R.C.S.Eng., District and Workhouse Medical Officer of the Llandoverly Union.  
 BURGESS, ARTHUR H., F.R.C.S.Eng., M.B., Ch.B., M.Sc.Vict., Surgical Officer and Medical Superintendent of the Manchester Cancer Pavilion and Home.  
 HAWORTH, STREANER R., M.D., B.Ch., R.U.I., District Surgeon of Bredesdorp, Cape Colony.  
 HEWLETT, RICHARD TANNER, M.D., M.R.C.P.Lond., Professor of General Pathology and Bacteriology in King's College, London.  
 PABRETT, EDWARD E., L.R.C.P.Lond., M.R.C.S.Eng., Assistant Medical Officer at the Brentford Infirmary, Workhouse, and Schools.

- PARSONS, CHRISTOPHER T., M.D.Lond., Medical Officer for Receiving School for Children at Parson's Green.  
 THOMSON, ST CLAIR, M.D., M.R.C.P.Lond., F.R.C.S.Eng., Assistant Physician for Diseases of the Throat in King's College Hospital.  
 WATSON, JAMES, L.R.C.P., L.R.C.S.Edin., has been appointed District Medical Officer of the Ailwinck Union.

## Vacancies.

- Birmingham and Midland Skin and Urinary Hospital, John Bright Street.—Surgical Assistant for six months, renewable. Honorarium at rate of 50 guineas per annum.  
 Brecon Infirmary.—Resident House Surgeon, unmarried. Salary £100 per annum, with furnished apartments, board, and attendance.  
 Brighton, Hove, and Sussex Throat and Ear Hospital, Church Street, Queen's Road, Brighton.—Non-resident House Surgeon. Salary at rate of £75 per annum.  
 Bristol General Infirmary.—Casualty Assistant House Surgeon. Salary £50 per annum, with board, residence, &c.  
 Carlou Union.—Dispensary Midwife. Salary £28 per annum. Applications, enclosing diploma and testimonials, to the Presiding Chairman. (See Advt.)  
 City of London Hospital for Diseases of the Chest, Victoria Park, E.—Second House Physician for six months. Salary at rate of £30 per annum, with board, residence, and washing.  
 Devon County Asylum, Exminster.—Third Assistant Medical Officer. Salary commencing at £125, and increasing at the rate of £10 per annum to £155, with board, residence, &c.  
 Devonshire Hospital, Buxton, Derbyshire.—Assistant House Surgeon. Salary £50 per annum, with furnished apartments, board, and washing.  
 Guest Hospital, Dudley.—Assistant House Surgeon for six months. Salary £40 per annum, with residence, board, and washing.  
 Kent and Canterbury Hospital.—Assistant House Surgeon, unmarried. Salary £60 per annum with board and lodging.  
 Lewes Dispensary and Infirmary and Victoria Hospital.—Resident Medical Officer. Salary £100 per annum, furnished apartments, &c.  
 Liverpool Dispensaries.—Assistant Surgeon. Salary £100 per annum with board and apartments.  
 Nottingham General Dispensary.—Assistant Resident Surgeon, unmarried. Salary £160 per annum, increasing £10 every year, with furnished apartments, attendance, light, and fuel.  
 Oxford, Combined Rural and Urban District Councils of.—Medical officer of health. Salary £750 per annum.  
 Royal Cornwall Infirmary.—House Surgeon, unmarried. Salary £100, increasing by £10 a year, with board (excluding stimulants) and apartments.  
 Royal South Hants and Southampton Hospital.—Junior House Surgeon for six months. Salary at rate of £50 per annum, with rooms, board, and washing.  
 Rubery Hill Asylum, Barnet Green, Worcestershire.—Junior Assistant Medical Officer. Salary £130 per annum, with board, furnished apartments, &c.  
 Somerset and Bath Lunatic Asylum, Wells, Somerset.—Medical Superintendent. Salary £600 per annum, with furnished house and allowances.  
 University of Glasgow.—Examiner for Degrees in Medicine and Science. Salary £30 per annum. Applications, enclosing testimonials, to Alan E. Clapperton, Secretary. (See Advt.)  
 Urlingford Union.—Trained Night Nurse. Salary £50 per annum. Application, enclosing diploma and copies of testimonials to M. P. Dowling, Clerk of Union. (See Advt.)  
 Victoria Hospital, Folkestone.—House Surgeon. Salary £100 per annum, with board, residence and laundry.  
 West Africa.—Three Medical Officers. Salaries offered £40 per month, plus subsistence allowance, first-class passages, and outfit allowance.  
 West Herts Infirmary, Hemel Hempstead.—House Surgeon, single. Salary £100 per annum, with furnished rooms, board, fire, lights, washing, and attendance.

## Births.

- CALEY.—On July 29th, at Colville House, Ealing, the wife of Guthrie Neville Caley, M.D., of a son.  
 LANGFORD.—On July 25th, at Weston Park, Crouch End, N., the wife of C. Harris Langford, M.B.Lond., of a daughter.

## Marriages.

- EVANS—BEENHAM.—On July 23rd, at St. John the Divine's, Richmond, David Robert Powell Evans, L.R.C.P.Lond., M.R.C.S.Eng., L.S.A., to Jessie, daughter of Charles Beenham.  
 HORSFALL—CAMPBELL.—On July 24th, at Ho'y Trinity, Melrose, Charles Edward Horsfall, M.B., Bedale, Yorkshire, to Lillias Marianne, daughter of Robert Hume Campbell, of Glendaruel, Argyshire.  
 STABB—FROUDE.—On July 30th, at Marylebone Parish Church, Ewen Carthew Stabb, F.R.C.S., of 57, Queen Anne Street, W., eldest son of William Henry Stabb, of Ilfracombe, to Emma Langworthy, daughter of the late James Henry Froude, of Newent, Glos.  
 WATTS—TASSELL.—On July 31st, at St. Andrew's Church, Fulham, Alexander Minter Watts, M.B., B.S., of Tollthorpe House, Holbeach, Lincolnshire, son of Captain James Samuel Watts, R.N., to Grace Evelyn, fourth daughter of the late Robert Tassell, Esq., of Bocky Hill, Maidstone, Kent.

## Deaths.

- HORSFALL.—On July 23rd, at Newland House, Leamington Francis Horsfall, M.R.C.S.Eng., L.R.C.P.Edin., aged 80 years

# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXIII.

WEDNESDAY, AUGUST 14, 1901.

No. 7.

## Original Communications.

### RESIDUAL LUNATICS AND RECENT LEGISLATION.

By M. J. NOLAN, L.B.C.P. & S.I.,

Resident Medical Superintendent, Down District Asylum.

By the term "residual lunatics" I propose to designate collectively the groups of insane persons at present located in the wards of the workhouses throughout Ireland. The "recent legislation" to which the title refers embraces those clauses (Sec. 76 (1), (2), (3), and (4) of the Local Government (Ireland) Bill, 1898, which have been enacted to ameliorate the miserable condition of the comparatively small proportion of the insane members of the community comprised in the above-mentioned groups. The object of this communication is to consider the consequences which may follow the operation of the Act, if the clauses are put into practical effect, without some necessary precautions.

The adoption of the term "residual" in preference to the words of the 76th sec. "not dangerous to themselves or others," needs no apology to recommend it to those who understand that no one expression can adequately convey an inclusive idea of the various psychical conditions which are the characteristics of the thousands of mentally affected persons still retained in the workhouse. Elsewhere to the public I have pointed out that the expression "chronic harmless lunatic" is a crude legal term, convenient perhaps, but faulty certainly; that the "harmless" and "dangerous" phases in the popular acceptance of those terms are often interchangeable; and that we who spend so much of our lives in the association with the insane would hesitate to ascribe a limit to the potential "dangerous" element in an apparently "harmless" lunatic. It must then be admitted at the outset that the looseness of a popular term to indicate the chief features of some thousands of persons who have little in common apart from poverty, location, and mental degeneration in all its varying aspects, must needs lead to contingent errors in its application. "Dangerous," *vide* the dictionary, means "perilous, hazardous, exposing to loss, unsafe, full of risk," and as exemplification the great Macaulay quotes, "*It is dangerous to assert a negative*"; not inapt in the present instance, when the parliamentary draughtsman has converted so many entities into one huge cypher—pathological entities, no doubt, but they count for something when they come into our calculations for asylum accommodation. To those who have lived among the insane nothing, perhaps, is more striking than the working out every now and again of the "unknown quantity," so to speak, in the problem of a disordered mind. That "it is

the unexpected that always happens" is equally true of sane and insane. One morning we are astonished when Vere de Vere, an exclusive aristocrat, marries his cook; suddenly, too, an apparently passive weak-minded patient develops an acute paroxysm of suicidal fury, and reveals an unsuspected volcano of passionate feeling. In an ordinary asylum the "chronic harmless lunatic" (whose name judging from the free use of the term would indeed be Legion) is in point of fact a by no means common individual—passive, weak-minded creatures no doubt abound, but certainly they are not free from risk of physical and moral injury to themselves and others. That this apparently "harmless" state of quiescence is largely due to the asylum environment which supplies the asylum backbone to these psychically invertebrate people, is sadly illustrated by the following case:—J. S., a good-looking, intelligent, middle-aged man, of kindly habits, gentle disposition, and little strength of character had lived in the asylum for years. He was admitted suffering from mild melancholia due to business losses, but being of an easy disposition soon reached his normal level, which had been marked by a tendency to lean on others for moral support. During his illness his wife and family emigrated, so his immediate ties were severed. He professed his inability to face the world afresh in view of the altered circumstances, but worked well and willingly in the asylum. He became a "liberty patient," working alone in the garden, going to the country for walks, and acting as a messenger. He was clean and neat in his habits, careful in his dress, solicitous about his health and personal comforts, and always declared he hoped some day to begin life again outside the asylum. After years the crave for liberty predominated over his other feelings. Every effort to get him work and a home was unsuccessful. He at last besought that he should be sent to the workhouse of his district, where he was confident he could act as a wardsman, and would not be regarded as a "lunatic." His wish was granted; he left the asylum full of gratitude and hope, buoyed up by the good wishes of all, as he had been a favourite; and with a sense of independence as he was the recipient of a small outfit and a little money—parting gifts from the staff. Some few weeks later the master of the workhouse reported that he had escaped; the guardians directed that the wall of the lunatic airing yard should be raised several feet to prevent a recurrence of such conduct. Meanwhile search was made for the missing man, but no trace could be found. Weeks passed by, when one of a number of inmates sent by the master to do some work in a detached building wandered to the upper room of the house, where, to his horror, he found a shockingly decomposed corpse of a man, suspended from the rafters, and gnawed by rats. This was the sad end of one who was, apparently, a typically "harmless" unatic; had he been detained in the asylum he

would, no doubt, have lived out his natural life a useful member of the community in which his lot was cast. There are in asylums, at present, scores of similar apparently "harmless" lunatics, who require the moral support of their environment to protect them from some such fate. Medical superintendents of districts asylums are well aware that the cases which heretofore have been transferred from the workhouses are, by no means, as a rule "chronic harmless lunatics." Chronic, indeed, they too often are; but very frequently full of risk to themselves and others, as well as advanced in disease or age, or both. When chronic their habits are usually dirty, destructive and erotic, and when physically ill they exhibit the cachexia of air starvation incidental to their close confinement. Taking them all round they are, perhaps, on the whole the most troublesome, expensive, and most unsatisfactory, from a medical standpoint, of the year's admissions. They require all the control, care, and comforts that our asylums can afford. Is there any reason to believe that those still remaining in the workhouse wards will not exhibit, wherever located in the future, the same urgent conditions sooner or later? Does anyone with the most elementary knowledge of the circumstances suppose for one instant that if the residual lunatics of any county were brought *en masse* tomorrow to the county asylum of the district, the motley consignment of degraded humanity could be fittingly housed in a "chronic block." Would it not be the first and obvious duty of the superintendent to distribute them according to their physical and mental state, over the appropriate departments of his institution? Yet it is such a group it is proposed to place in an "auxiliary" and to maintain at a cost of some 5s. 6d. per week, of which the local taxation account is to contribute 2s. per head. So far then, it would seem that the provision necessary for the requirements of the residual lunatics is based on a misconception of their characteristics, and has, moreover, been very much underestimated seeing that they in no respect differ from those of the same class heretofore sent to asylums, where they cost the maximum sum for maintenance and tax the full resources of those institutions. It is also evident, as sadly illustrated by the case of J. S. that the comparatively small number of mild chronic cases of an apparently "harmless" character cannot be removed without risk from the district asylum where, moreover, they are for the most part willing helpers in the daily work, and so reduce the cost of paid labour. These chronic lunatics require the asylum environment, and the asylums as at present constituted require the assistance of this class to help in every department of labour, and so lighten the general cost. It is clear then, as has been abundantly proved by the complete failure of the clauses of the Lunatic Asylums (Ireland) Act, 1875, that transfer from asylums to workhouse wards should be avoided for every reason. It may be argued without fear of contradiction that the same reasons will still hold good wherever it is proposed to transfer apparently "harmless" chronic lunatics from the District Asylum to any institution of the proposed "auxiliary" type—in other words, to a few isolated wards grouped under the condition of workhouse life and forming receptacles for incurables, many of whom have yet wit enough to read and sensibility enough to be injuriously affected by the inscription writ so largely over its door—"Abandon hope all ye who enter here." So much, then, for the difficulties which attend the selection of cases for the "auxiliaries." Let us now see how the auxiliaries themselves are to be provided.

In February of this year the Local Government Board issued a circular to the County Councils, in which it was pointed out to these bodies that:—

"The following courses are now open to a County

Council, who should consider how any action of theirs might affect both asylums and workhouses:—

"1. To build a separate auxiliary asylum for chronic harmless lunatics, with a resident medical superintendent, and at least one assistant medical officer (Local Government Act, Section 84).

"2. To add, subject to the Lord Lieutenant's direction, by the erection of buildings less elaborate than the original ones, a new department to an existing asylum, and to place it under the resident medical superintendent of that asylum.

"3. To acquire and adapt some workhouse or other building, either as a separate auxiliary asylum, or, if the Lord Lieutenant so direct, as a department of some existing asylum."

Since this circular was issued some six months ago public attention has been directed to the subject in the general and medical press, and it may be taken as fairly representing the state of opinion to-day, with regard to the different courses, that No. 1 is impracticable because of its small numbers to be provided for, say 4,000 spread over twenty-two districts, or 180 to each. Beyond a reduced capitation grant the constitution of the auxiliary from an administrative point of view would in no way differ from the existing district asylum.

No. 2 has been considered feasible to some extent, but it creates a crop of difficulties by introducing a second class treatment, so to speak, side by side with what has been already approved—two systems under the same management and one roof.

No. 3 has found little favour, inasmuch as the circular of the Local Government Board suggests that it would be cheaper to build new than to adapt old buildings. This statement has been supported by the estimates received for converting workhouses into auxiliary asylums. Financially the adapted workhouse as an independent asylum is open to the same objection as No. 1, and as a "Department" "of an existing asylum" to the same objection as No. 2.

An examination of the propositions set forth in the circular when based on a full knowledge of the conditions which practically affect the questions regarding the due care, proper supervision, and adequate treatment of the insane brings to light the following facts:—

1. That in the words of the Local Government Board's circular, "humanity demands" the removal of the 4 000 insane from workhouses, who must be provided for elsewhere.

2. That the class of patient for whom auxiliaries are proposed cannot be conveniently, beneficially, or economically grouped in such institutions.

3. That the accommodation proposed would under Schemes 1 and 2 be as costly, and the administration more expensive than that of existing asylums, though nominally established on economical lines for the less curable cases.

4. That no asylum can be properly carried on at a minimum cost of 5s. 6d. per head, and that the cost in an "auxiliary," either as a separate institution or a department, would exceed that figure, hence the 2s. grant is inadequate.

5. That in face of all the circumstances, the number and nature of the persons to be dealt with, the object in view, the financial aspect of the question—the only one, I regret to say, the public has seriously considered,—the creation of "auxiliaries" is unjustifiable, and that the wisest course, in the ordinary country districts at least, is to increase the existing asylum accommodation on the ordinary lines. In large urban districts, or conjoint districts, other steps may perhaps be taken with advantage, such as boarding out, or by erecting additional asylums.

Whether or not lunacy is on the increase is a more or less problematical question we need not

stop to consider, since the stern fact remains that the need of asylum accommodation is yearly increasing, and that the Act of 1898, with one stroke, has practically certified some 4,000 individuals of unsound mind, now located in workhouses. These persons are collectively, and for the first time legally, declared to be insane. It is recognised that they are in urgent need of adequate care; and it is provided that they may be (under the special conditions enumerated in the different courses set forth in the explanatory circular of the Local Government Board) removed elsewhere. This recognition of the malady has been long desired; if tardy, it is none the less welcome, but what can be said of the proposed remedy, but that it is of a weakly palliative kind, altogether inadequate to touch the root of the matter, and of that class of cures which are proverbially worse than the disorder they are applied to ameliorate. The establishment of starved "auxiliaries" on the lines indicated is not the course to bring these unfortunates to their destination; it is simply sending them to lie on a siding until the block is cleared in the main line to their proper terminus. In this siding they may remain for an indefinite period, suffering the miseries of isolation and its consequences, while their late companions on the journey are going gaily along. *En passant* note may be taken of the time this new departure takes place, as it is verily a psychological moment in the history of Irish Bumbledom. For to-day we find boards of guardians discussing menus of improved dietaries, trained nurses are displacing "Gamps" and "handy women," sanitation is at last asserting its importance in all departments of public health; the same epileptics are to find a haven in central homes; the children are to be removed to the more beneficial surroundings of district schools; the unfortunate consumptives are at last to have pure air and an abundance of it in sanatoriums. The new broom finds plenty of work in clearing out the dirty corners. When the reformed house is swept and garnished the "Societies for Brightening Workhouse Life" come along with music and song to cheer up the dreary days of the penal imprisonment of abject poverty. So the removal of the chronic and euphemistically dubbed "harmless" lunatic is necessary—the most repulsive and glaringly reproachable object must forthwith be swept into the outer darkness. One is inclined to ask, how does it come about that now when at last the dawn appears rosier for the pauper than he who is the veriest pauper of all—one bereft of means, of health, and of mind—is condemned to an existence which experience has shown could not be adequately supported in the past on the same provisions which it is proposed to dole out to them in the future? In point of fact, he is not only to stand still, but to go down hill, when all his former companions cry "Excelsior." Herein lies the practical point of this new departure. *The estimated cost of a lunatic in an auxiliary is fixed at a sum which has in the past proved absolutely insufficient to supply in the most meagre manner the limited wants of the afflicted poor of all classes in our workhouses.* It must be conceded also that the amount of relief granted to reduce local taxation is hopelessly inadequate to appreciably lighten the burden which proposed "auxiliaries" would, if established, throw on the taxpayer, that is to say, if these auxiliaries are to be created for the betterment of the chronic insane. But why create yet another class of institution in this small country already weighed down with too many institutions of all kinds? Such a course objectionable from medical and financial standpoints, can be avoided by increasing the accommodation of the county asylums, when the lunatics sent to them would benefit by appropriate surround-

ings, and the counties benefit by the larger grant. To this it may be urged that the county asylums are in some few districts too large to admit with advantage of a greater growth; possibly too some few superintendents who find themselves daily beset by the worries of the cramped conditions of crowded wards may say that instead of an increase they desire a reduction in the number of the patients. Such objections can be easily swept aside. If a district asylum has reached the stage of unwieldy bulk by all means let it be reduced by the creation of a legitimate branch of the same constitution, and not propagated by a "sport" of degeneracy such as an "auxiliary" would prove to be. The superintendent who seeks to throw off the embarrassment of accumulated cases should consider the broad question of the treatment of the chronic insane with a view to the general conditions, and not to local exigencies. It is particularly dangerous for those superintendents whose asylums in the sister countries have been raised to the highest possible point of excellence in general equipment, in the development of special departments for scientific research and in the cultivation of classical clinics, to take a summary view of the disposal of the chronics. No doubt in the fulness and amplitude of their administrative powers and success they feel that, while the "chronic" still crowd their wards, the idol of perfection they have set up has still but feet of clay. To such superintendents it may be said: If you, having done all any one individual can humanly do for the 1,000, 2,000, or 3,000 patients under your care, find that the "chronics" do not appreciate the æsthetic comforts of your corridors, that your laboratory shelves groan with the unexplored pathological material of a kind which offers no prospect of new or attractive work, that "the babbling of green fields" of the dement does not fix with the same interest the attention which your clinical class gives to the highly-seasoned fabrications of a delusional adolescent; if for these reasons you deem it desirable to be rid of the incubus, pray be mindful that the one has as full a claim on the public purse as the other, and that it is outside your province to suggest the restriction of the legitimate comfort of demented old age in order to indulge the more recent cases in what you admit is the border land of luxury. Remember also that you are rolling along in urban areas on the hub of civilisation, and be not unmindful of others less fortunate than you who have to labour along the rut in country districts. Having successfully passed the goal, do not forget that others have but started in the race of progress. Let not your specialty sink the broader spirit of humanity that alone can alleviate the actual living suffering which the highest microscopic power has, as yet, failed to locate, though its effects are palpable to the most unobservant." But it needs no reasoning to prove to the medical reader how "auxiliary" asylums of the projected type are unsuited to the wants of the class they are intended to accommodate, any more than it requires other proof, than is established by an examination of the financial aspect of the question, to show that such institutions are unacceptable to over-taxed ratepayers. Still, the necessity for some accommodation remains, and the problem is how is it to be met? A section of the laity indeed have, in the profound ignorance of the real conditions, sought to cut the Gordian knot by proposing "auxiliaries" so-called, to consist of adapted buildings, supervised by a person of the status of a head attendant and supported by "a few vigorous women, neither squeamish or over-refined." It is unnecessary to dwell on this project save to record it as, perhaps, the most astonishing proposition of an age, characterised by astounding projects, from all of which, however, it differs in the

fact that it is as retrograde as others are progressive in character. In its simplicity lies its danger.

It seems akin to the line of reasoning which a few years since made it seem clear to a certain section of Parisian "souls," that the best means to promote the highest spiritual feeling and to divest themselves of the trammels of our too elaborate system of modern life, rendered it necessary that they should migrate to the woods of Normandy, where, substituting fig-leaves for chiffons, they should resume the unfettered simplicity of promiscuous association! Amidst sylvan delights they were to dig up roots for food, and enjoy sexual relations of so primitive a kind that rendered formalities unnecessary—but these are details. One can readily conceive, however, that the details of life in an "auxiliary" run by those sturdy, coarse women, would furnish scenes no less novel and sensational which would horrify no one more than the ecclesiastical dignitary who, in the fulness of his heart, but with a want of the due knowledge of collateral circumstances, outlined a benevolent scheme for the benefit of his flock.

Few legislative Acts there are that do not require amendment, and no Act, perhaps, dealing with the insane ever so urgently demanded amendment as the Local Government Act, 1898, where it touches the provision for the chronic insane. And yet a very little change may set the matter right, as it only needs some precautionary clauses and a little more liberal pecuniary treatment to make the evident intention of the Legislature practical and efficient. Let the auxiliary buildings be still provided, proximate to the district asylums, let the 4s grant be given to each patient therein, and let the transfer of patients from the parent asylum, and the auxiliary be rendered as easy as the changes in the mental and physical states of the patients are rapid. This is not too much to ask in face of a decreasing sane population, an increasing insane community, and a local taxation account based on a standard year, when every department of the Poor-law service was notoriously inefficient owing to financial starvation. Excellent in intention, but hopelessly weak in effect, the Act offers a temptation which carries with it certain punishment. The 2s. grant will fall far short of the wants of the chronic lunatic if *adequately* provided for in an "auxiliary," and the deficiency must be drawn from local resources already suffering from overstrain. Let every certified lunatic get the benefit of the 4s. grant, and treatment of a rational kind in suitable asylum wards, and then the evil ceases to exist. The cure is palpable, and should be recommended to those who can exercise it for the dual benefit of the afflicted insane and the hard-pressed taxpayer. The grant of the larger sum would be of infinitesimal consideration in the Imperial Budget, yet it would be for a section of the community "an indemnity for the past, and a security for the future."

### CERTAIN POINTS IN THE OPERATIVE TREATMENT OF RENAL CALCULUS. (a)

By J. HUTCHINSON, jun., F.R.C.S.,  
Surgeon to the London Hospital.

IMPROVED methods in skiagraphy have rendered it possible to detect renal calculi whatever their composition, so long as the subject is not exceptionally stout or the calculi exceptionally small. The time required for a successful exposure to the X-rays can be brought down to fifteen or even ten seconds, which may be regarded as instantaneous photography.

(a) Abstract of Paper read at British Medical Association Annual Meeting, 1901.

During this short exposure it is easy to avoid all blurring from respiratory or other movement on the part of the patient. Uric acid calculi give better results with these short exposures than with the long ones that have been hitherto customary. The exact size, number, and position of stones in the kidney can thus be determined before the operation, and the kidney subjected to the smallest degree of injury during the latter. In the majority of cases renal calculi can best be reached through an incision across the back of the pelvis, though it is necessary in some cases to go through the cortex. With the aid of the X-rays it will be almost always possible to place the incisions directly over the stone or stones. To bring the kidney out into the wound is sometimes both difficult and dangerous, and to bisect it through the convexity (splitting the organ) may cause serious hæmorrhage, or lead to a urinary fistula. Provided the urine is fairly aseptic, a condition which can be generally brought about by the previous use of urotropine, a wound made through the pelvis, whether sutured or not, will heal readily. If sutures are used they should be of the finest silk, and should not penetrate the whole thickness. The X-rays enable very small calculi to be detected, and they should be removed by operation as soon as this is done, since small solitary calculi are among the most dangerous of all.

Occasionally whilst the calculus is on one side the patient's symptoms are referred to the other. A striking instance of this was narrated, in which the X-rays prevented a serious mistake being made. The evidence of skiagraphy confirms the belief that stones occur simultaneously in both kidneys in the proportion of about one to fifteen one-sided cases. This information may be of the utmost importance to the surgeon before operating.

By means of the X-rays in some cases a supposed renal tumour or hydronephrosis may be shown to depend on a small impacted calculus, and thus nephrectomy be avoided. Since such reliance can be placed on the evidence of the X-rays in skilled hands, it is obvious that the operation of nephrolithotomy in the absence of a stone will become much less frequent than has been the case.

Exploratory nephrotomy is not without risk and (supposing there is no calculus found) very little may be gained by the operation. It is, however, admitted that a few cases of nephralgia are permanently relieved by it.

The paper contained cases illustrating the above points, and technical details as to the best methods of skiagraphy in renal calculus.

### THE ROLE OF TOXIC ACTION IN THE PATHOGENESIS OF INSANITY. (a)

By Dr. FORD ROBERTSON.

HIS own views, he observed, were based chiefly upon the recorded observations. Whatever else mind might be, it was, in the first place, a product of the functional action of certain of the cerebral neurons. For the normal manifestation of this functional action three factors are essential, namely, (1) Integrity of the anatomical elements which form the physical basis of mind, (2) the maintenance of suitable nutritional conditions of these neurons, and (3) those sensory impulses which, commencing to impress the anatomical elements at an early period of life, gradually endow them with their special functional power and of which the almost continual stimulus is required in order to call these func-

(a) Introductory remarks to a discussion at meeting of British Medical Association, 1901.



tional powers into action. Morbid mental action might primarily depend upon a fault on the part of any one of those factors. He discussed the importance that was to be attached to a fault in the cortical neurons in the pathogenesis of insanity, and the parts played by sensory impulses and by alterations in the nutritional conditions. There were two respects in which the materials brought to the neurons by the blood vessels might be unsuitable for their healthy nutrition. There might be a deficiency of certain constituents which were needed for their normal metabolism, or certain substances might be present which were taken up by the cells and then disordered their metabolism. Any such substance was a toxin. He enumerated the various possible non-toxic primary etiological factors in the pathogenesis of insanity, and contended that, when these were fully taken into account, there remained a very large majority of cases of insanity in which the primary etiological factor was toxic action. He entered shortly into the question of the nature of predisposition to insanity, and pointed out that it was based upon at least three entirely different conditions. By far the larger proportion of such predisposition depended not upon any condition that could rightly be termed degenerative, but merely upon one extreme of those wide though limited differences that individuals exhibit in the reactive qualities of their cortical neurons to various forms of toxic action. He insisted strongly upon the importance in certain cases of the indirect action of toxins upon nerve-cells through injury to the nutrient vessels. The various toxic conditions which tended to affect the nerve-cells might result from (1) exogenous toxic agents, (2) infections, and (3) auto-intoxication and auto-infection. In these respective categories special importance was attributed to alcohol, syphilis, and auto-intoxication and auto-infection from the gastro-intestinal tract. He dealt especially with the last named, and maintained that it had far greater importance than was generally believed. In his opinion various forms of toxæmia of gastro-intestinal origin were the chief factors in the pathogenesis of a large array of acute and chronic diseases, including several forms of mental disease. He mentioned especially arterio-sclerosis, senile insanity, general paralysis, locomotor ataxia, chronic alcoholic insanity, dementia præcox, acute and chronic mania and melancholia, idiopathic epilepsy (as the determining cause of the fit), and chronic Bright's disease. He held that the large majority of cases of insanity were not primarily diseases of the brain at all, but depended upon the action of toxins derived from elsewhere, which affected the functional activity of the cortical neurons by disordering their metabolism and often permanently damaging and even destroying many of them. He agreed with Dr. Mercier that "insanity is a disease of the whole man, a disease of the whole organism, which can only be properly understood and properly dealt with when so regarded."

### SOME POINTS IN THE MANAGEMENT OF ECZEMA. (a)

By HENRY WALDO, M.D., M.R.C.P.,

Physician to the Bristol Royal Infirmary, and in charge of the Department for Diseases of the Skin.

THE author urged that an attempt should always be made to cure eczema. Whether it depended upon the action of micro-organisms, or whether this is disproved, as Kaposi thinks, by the fact that eczema may be provoked at will in any part of the skin of any person by mechanical, chemical, or thermal

stimuli, he considers that daily cleansing the part affected with the juice of bran, or starch, or boiled oatmeal diluted with rain-water, should be carried out.

He thinks the sound parts of the skin should be washed daily with soap and water, as by so doing the eczematous surface is much benefited, and illustrated this by stating that if a different application is used for each side of the body in a symmetrical eruption, it must not be taken as a test of the relative value of the two agents, as one side always responds to a successful treatment of the other. This sympathetic relation of the two sides should be therefore taken into account by cleaning and polishing the general surface of the body which is not the seat of disease. He advised soothing or stimulating applications to protect the part, and to a wet eczema he thinks a lotion is better able to come into close contact with the living tissues. He believes internal treatment is also necessary, and mentions the change of opinion which has come over the medical world in regard to the relative importance of attention to the microbe in tuberculosis, as compared with the more important elements of the nutrition and hygienic condition of the patient.

If auto-intoxication is suspected he knows of no better intestinal antiseptic than benzo-naphthol, which is odourless and tasteless. He thinks all alcohols increase the itching, and should, as a rule, be avoided. If a microbicide is needed salicin is recommended. Unless diabetes is present he does not believe in restricting the diet. He does not find that sea air aggravates eczema in anything like the majority of cases. Woollen underclothing is said to act as an irritant in some cases, and silk, muslin, or linen should, he thinks, be substituted.

### THE IMPORTANCE OF THE X-RAYS AS A MEANS FOR THE EARLY DIAGNOSIS OF TUBERCULOSIS. (a)

By Dr. ESPINA Y CAPO,

Of the Royal Medical Academy of Madrid, Professor of Tuberculosis in the Provincial Hospital of Madrid; Inspector of Public Health, &c., &c.

My work comprises three parts: first, radioscapy; secondly, radiography; and thirdly, the technique of both in relation to tuberculosis. In the first part I shall speak of radioscapy in cases of sound and tuberculous lungs; in the second of the use of radiography in the different stages of the disease, whilst in the technical section I shall refer to the best method of obtaining the best results in both.

**RADIOSCOPY.**—Radioscapy as a means of diagnosis in tuberculosis has constituted, since its appearance in the clinical field, one of the means in which the greatest hopes have been placed, so much so that since the fourth congress on tuberculosis held in Paris, it has been considered the equal both of percussion, superficial and profound, and of auscultation.

In that fourth congress, however, we could not speak so affirmatively because we were not yet in possession of positive instances which would leave no room for doubt. To-day it is already impossible to detract from this potent means, admitted as such in all countries and by all practitioners.

Partisan as I am of the parasitic doctrine, I will not treat of the radiographic diagnosis of open pulmonary tuberculosis, because the analysis of sputum, and the presence in it of the bacillus of Koch, affirm so positively the existence of tuberculosis, that no physician can detract from this method. Radioscapy, in the case of open tuberculosis, serves only as a potent means of

(a) Abstract of paper read at Annual Meeting of British Medical Association, 1901.

(a) Abstract of paper read before the British Congress on Tuberculosis.

settling the topography of the lesions, and although this is very important, it does not deserve to fix our attention, because we prefer to employ our time studying the true use of X-Rays in the diagnosis of pulmonary tuberculosis in its first period full of doubts, and in which therapeutical intervention, being more rapid and convenient, is also more efficient.

There is another question of transcendent importance, in which the X Rays have assisted our investigation with such clearness, that this peculiar aspect of the question justifies our fixing it in our attention. I refer to glandular tuberculosis, the commencement, in many cases, of pulmonary tuberculosis, and in all the inseparable companion of the disease.

Apart from the data given by all authors in explanation of the changes of colour from which the radioscopic image of the lungs suffers in the incipient, settled, and cavernous stages, we shall not refer to them, because at this Congress we are obliged to present subjects of some novelty. I am going to mention, however, two circumstances, which, I believe, perhaps through ignorance, possess that peculiarity, and which we can only observe, especially one of them, by radioscopy.

Radioscopy constitutes a powerful means of studying the dynamic forces. It is not possible to see by radiography all the functions and all the movements that characterize each function. For this reason the normal physiology of, for example, a joint during the different phenomena which constitute movement and action, can alone be seen on the fluoroscopic screen, an impossibility with the radiographic plate.

The two phenomena to which we are about to refer appertain to actions of an organ in a state of movement, and for that reason can only be observed by radioscopy. The first is the heart. Ever since Wells drew attention to the diagnostic value of tachycardia, all specialists and those who devote themselves specially to the study of tuberculosis, have set great store upon this datum, raising it to an important position in the early diagnosis of tuberculosis. One of the most efficient means of verifying this datum is by fluoroscopy. As we never lose sight of this diagnostical resource in our department of tuberculosis, we can affirm, in an indubitable manner, that, with the fluoroscopic screen, the datum of Wells is seen in more than 94 per cent. of cases of tuberculosis with so much clearness as to remove all doubt on this subject. I shall, moreover, refer to a sign which, I think, has not been touched upon by other authors, namely, that this tachycardia is not rhythmical. There is another sign in the heart of the tuberculous, but we shall study it when we treat of radiography.

The second example that may be taken for radioscopy, being essentially functional, and one which we have not seen referred to by any other author, appears to our observation with as much, or even more, constancy than tachycardia. We refer to the visibility of the diaphragmatic excursion, both in inspiration and expiration, a phenomenon that, as is easily understood, can be appreciated neither by common means of exploration nor by radiography. This phenomenon, which under normal conditions is rhythmical and symmetrical on both sides, in tuberculosis is neither rhythmical nor symmetrical. We have observed that in the tuberculous the diaphragm does not rise to the same height on the sick as on the healthy side, and that when the two lungs are affected the ascension is shorter on the worst side; in such manner, in the case of a tuberculous patient whose diaphragm on one side has no ascension or where it is very short, we deduce from this the correspondingly greater impermeability of the lungs.

Accepting also in the case of radiography of tuberculous lungs, as much as we have related respecting the several degrees of transparency and depth of shadows in the first stages, darkness in the tract of the ganglionic and lymphatic vessels, opacity in the congested lung, and very great transparency of the caverns, we shall only say with regard to radiography that it is possible with it to discover the data, also of a certain novelty, in the radiogram of the tuberculous.

In our remarks on tachycardia when dealing with radiography, we said that the heart gives a sign easier

of record by radiography than radioscopy. Since the adoption of this valuable means of diagnosis, the small size of the tuberculous heart has attracted our attention, being a true cardiac atrophy. If this, as we believe, is a positive indication of tuberculosis, we shall arrive at a definitive early diagnosis with greater ease if we find in our radioscopic and radiographic explorations small heart, especially if the investigations are accompanied by tachycardia; moreover, we have an explanation of the relations existing between the smallness of the heart, aortic narrowness, and the frequency of tuberculosis in such subjects, which determine the rule existing among these phenomena.

Another datum that may be observed is the peculiar shape of the intercostal spaces. In other works relative to the same matter, we have referred to the difficulty of performing percussion on tuberculous patients. The causes of this difficulty are two: the first the extreme narrowness of the intercostal spaces, it being impossible to place the fingers between the ribs, and the second the conical form of the tuberculous thorax. Now before the appearance of the Röntgen method we could hardly understand these difficulties, but since the clinical adoption of this new system, the reasons become apparent. In the radioscopic image is observed a disposition of the ribs strongly resembling the peculiar arrangement of roof tiles, in such a manner that the superior rib almost touches the anterior face of the inferior rib, the intercostal space being so small, particularly from the fourth rib downwards, that it is difficult to place the finger upon which percussion is made. With radioscopy this disposition of the ribs is very clear, and functional phenomena corresponding to the diminution of the respiratory excursion in the tuberculous impossible to diagnosis in any other manner, is very evident. As we see, radiography permits us to know data of transcendent importance in the life, in the functional, in the active, and for this reason it is not possible to rescind from this recourse in the diagnosis of tuberculosis.

The transient nature of the radioscopic image, and the necessity of taking it permanently, emphasises the need of closely following with radiography the datum described in radioscopy. It is true that radiography cannot give us any data of function, but in exchange, with this second method, anatomical facts remain permanently indelible, as a book ever open to study.

Amongst the most interesting facts that we can select from our experience in radiography are the deformities of the bones characteristic of tuberculous thorax. There are in the thorax certain bones, which for their bearing on respiration and also from the muscles that originate from them, are organs of transcendent importance in the osseous respiratory apparatus. They are the clavicle and the scapula. Their position, form and size also produce very important modification in tuberculosis.

In taking a radiograph of a tuberculous subject, we see the modifications of these bones; the clavicle principally presents an augmentation on the inflection of its external extremity, and resembling a hyperplasia, but without being sufficient to constitute an alteration of the tuberculous epiphysis, takes the shape of the head of a mace. The scapulas are higher, and the internal and superior vortex is more elevated, swinging towards the centre the point and internal edge which are raised on account of the peculiar disposition of the ribs and spinal column.

Without entering into the pathological physiology of these facts, which entirely depends upon the great respiratory necessities of the tuberculous, united with the reduction of their respiratory field, we must remark that radiography shows these pathological heteromorphics with great clearness. The roof-tile disposition of the ribs, of which we have spoken before in speaking of radioscopy, can be seen in an evident and clear manner by radiography. Besides these deformities of the skeleton, radiography also shows us the small size of the heart. Respecting this organ radiography has achieved wonders, not alone in tuberculosis, but as to its real situation; but putting aside this latter fact, and circumscribing also those data which we can recognise in tuberculosis by the

heart, we shall mention two that have, we think, a certain novelty and importance.

The first is the greater extension of the heart towards the lines of Traube and Friedreich on the right side, this fact showing, in our opinion, a compensatory insufficiency of the tricuspid valve, and, for that reason, ventricular hypertrophy on the right side; the radiographic image of the tired heart in tuberculous persons thus acquires a strong resemblance to the image of the tired heart of the emphysematous. The second datum refers to the special form of the heart of the tuberculous persons which thus acquires a strong resemblance to the image of the tired heart of emphysematous. The second datum refers to the special form of the heart of the tuberculous, similar to the foot of a Chinese woman in its left ventricular border, remembering the growth of the deformed foot of the Chinese. Respecting the lungs the facts of the first, second, and third periods are so classic that we do not consider them worthy to occupy your attention: for our part they are simply confirmative of what we related in the fourth congress held in Paris.

**TECHNIQUE OF RADIOSCOPY!**—To observe the wonderful phenomena of radioscopy under the best conditions of visibility, complete darkness is necessary, suppressing it until the light is produced by the Röntgen tube: for this purpose we have had a special box constructed, to conceal the light completely, provided with a simple mechanism adaptable to any exploration that may be necessary.

Another trouble that must be got over is the difficulty of applying the fluoroscopic screen, which is commonly rigid and mounted in a frame. In this form the screen can, in tuberculous cases, only be applied upon the sternum or upon the internal edge of the scapula. It is known that in radiographic images size and intensity depend upon the distance between the part under observation and the surface of the screen, so that with rigid screens it is not possible to obtain a corresponding equality of definition and intensity over all the surface, and to obtain such a result it is necessary to use a flexible screen mounted on card-board in such a manner that it can be adapted to the convexities of the thorax. One of our colleagues, a very competent person in these matters, Doctor Redondo, Fleet Surgeon of the Spanish navy, advises the employment in radioscopy, as a radioscopic screen of the strengthening screen whose image resembles in depth of tone the radiographic image, and gives as fine detail as the ordinary fluoroscopic screen.

This application of the strengthening screen makes the solution of the problem easy, because it avoids having to change in the laboratory the fluoroscopic material of which, as we have said before, the rigid screen is constructed.

This last modification of the fluoroscopic technique is relative to the examination of patients that must have fasted previously, to have obtained with more clearness the semi-lunar space of Traube, and to observe with greater ease the phenomenon of the diaphragmatic excursion previously referred to.

**RADIOGRAPHICAL TECHNIQUE.**—For some time we have omitted as much as possible the use of strengthening screens. This is not the moment to analyse in detail their advantage or inconvenience. I will refer, however, to one amongst its inconveniences which, I think, is pertinent at this moment, viz., the turbid and disseminated nature of the image. When, therefore, we treat of images that require great detail, obtained in subjects capable of enduring the exposure—a very short time—that is required to-day to obtain a radiograph, we refer to work without a strengthening screen in order to obtain a completely clean image, with richness of detail, especially in pleurisies and patients with but small caverns.

Another interesting subject in radiographical technique, that also gives clearness to the image, and richness of details, is the distance that should exist between the tube and the plate. Without discussing theory, but confining ourselves to the collected facts, we have succeeded in fixing this distance at 50 centimetres

from the thorax, at which we obtain the maximum richness of detail.

The last matter that will occupy us in this address, refers to the development of radiographic plates. We have tried nearly all modern and antique developers, from the iron classic and pyrogallic acid to diamido-phenol and diamido-resorcine, and from this study we have deduced the necessity of never developing in radiography with old liquids in any one proportion, as much with the developing as with the fixing agents; we use the diamido-phenol to 1·2 per 100, with sulphite of soda crystallised to 6 per 100 as a developer, and Enckel's (Swiss) hyposulphite to 25 per 100. With these products we make our baths instantly, that is for two or three radiographs only, especially in Madrid, where the purity of the Lazoya's water (4" hydrotrimetrics) permits of its employment in all photographic laboratories.

We finish, as we began, confident of having defined nothing either good or new; but the call of duty has bade us contribute our feeble forces to this concourse in which every altruism has its place in the fight with this dreadful tuberculosis.

## THE TREATMENT OF TUBERCULOSIS BY UREA. (a)

By ARTHUR H. BUCH, F.R.C.S.,  
Assistant Surgeon, Sussex County Hospital.

It is, I take it, generally granted that the most important factors in dealing with any cure for tuberculosis are susceptibility and immunity. Jenner first recognised the importance of the immunity of a portion of the community to a particular disease, and eventually his labours have procured the immunity of the rest from that disease. It was not, however, till comparatively recently that the importance of his work was understood. All the great workers in this direction, whilst studying susceptibility and immunity, have tended to be drawn in one direction, and that is the preparation of antitoxins, by means of the injection of which into the human body we can either render such immune to, or modify an attack already begun, by the germ peculiar to each disease. These antitoxins have been prepared from the growth of the different organisms concerned, under various conditions, and the result is that the chemical substances which have been injected into the tissues of those to be protected are powerful alkaloids or toxalbumins differing chemically from any combinations hitherto demonstrated in our organisations.

Now this class of antitoxins has so far proved of greater value in acute specific fevers, such as diphtheria, small-pox, typhoid and bubonic plague, than has the corresponding antitoxin in tuberculosis. But tuberculosis differs in many other respects from acute specific fevers. The former is a chronic disease, the latter acute. The tubercle bacillus is one of the family of organisms which are termed infective granulomata, the latter belong to a class which produce their toxic effects in the body without the formation of new growth around them. The tubercle bacillus has an exceedingly wide distribution, that of the others is, comparatively speaking, extremely limited. Every one of us has been exposed, some constantly, to infection by tubercle; comparatively few have developed the disease; whereas of those who, being unprotected either by a special antitoxin or by a previous attack, are exposed to active infection by any of the acute specific fevers, I presume it is safe to say that the great majority would develop such.

In other words, by far the greater proportion of mankind provide a fit soil for the growth of the germs of acute specific fevers, whereas a small minority only are capable of harbouring and developing in their tissues the tubercle bacillus. The majority of us, therefore, possess in our systems some vito-chemical combination or condition which renders us immune to any ordinary dose of infection by the tubercle bacillus, and it follows that that combination or condition must be actively

(a) Abstract of paper read before the British Congress on Tuberculosis.

hostile to the bacillus, for we are all exposed to the infection.

This substance, or condition, therefore, whatever it may be, in contradistinction to the antitoxins, must be such as is neither harmful nor foreign to the human organism. It most probably exists in some in a greater degree than in others; but, in any case, if we could induce in the tissues of the susceptible some difference in metabolism so that this substance or condition was introduced into or manufactured in their systems, there can be no manner of doubt but that we should rid the human race of tuberculosis.

It was by the observation that in his experience the gouty were particularly immune to tubercle that induced Dr. Harper, of Nottingham, to prescribe pure urea to the tuberculous with a view to increasing the amount of urea and uric acid in their systems, and it is because of the enormous importance that I believe attaches to this treatment that I am reading this paper.

Dr. Harper has published two papers full of interest in the *Lancet* this year (March 9th and June 15th), in which he mentions many cases of phthisis which, being apparently incurable, have recovered. I would draw attention to the fact that he was induced to try this treatment by the observation of the peculiar immunity of a small part of the community, namely, the gouty, to tuberculosis; in other words, for reasons similar to those which induced Jenner to try vaccination for small-pox. It is an extremely interesting fact to note that urea, in the shape of urine, has been taken from time immemorial as a medicine, and that the natives of India are at present using it in this way.

As the treatment is still on trial and in its infancy, the answer to the second must necessarily be uncertain. The following facts, however, will, I believe, be found to have a bearing on the case. Urea is one of the end products of nitrogenous metabolism, i.e., of the oxidation or reduction of proteid matter, and the medium in which most of the nitrogen excreted from the body is carried away in the urine.

Urea is formed, according to our latest knowledge, in the spleen, lymph and secreting glands, but principally by the liver. The original source of the nitrogenous matter, which eventually supplies urea, is, of course, the proteids consumed as foods.

It is evidently impossible at present to understand precisely why and how urea can act beneficially in tuberculosis, or what changes exactly take place on its re-entrance into the body. Urea contains nitrogen, as do these all important proteid matters. During the period of growth and development less nitrogen is eliminated from the body than during the decline of life. The balance of nitrogen, therefore, with absorption at one end of the scale and elimination at the other, plays an important part in the cell activity and vito-chemical constitution of the body. If we can prove that urea splits up during the process of absorption, and that its nitrogen is assimilated, it can only be assimilated in the metabolism of protoplasm. We shall then have established the curious fact that an apparently waste product, the result of a process of reduction by oxidation of protoplasm, on being passed through the mill, so to speak, a second time, assists in building up tissues similar to those from which it originally derived. The proof that urea is decomposed in the process of absorption and assimilation, and that its nitrogen is wholly or in part retained in the body, can only be ascertained with certainty by elaborate processes of analysis. With the general practitioner this is, as a rule, impossible, owing to lack of experience, time, and apparatus. But more experiments, including estimation of total nitrogen eliminated, will be necessary before definite statements can be made. Dr. Harper mentions in his paper that the urea in most cases is not increased.

A short description of some cases which I have treated in this way is as follows:—

CASE 1.—Man, *æt.* 36. Was deserted as an infant, and suffered from tuberculous disease of left ankle and

performed below the knee for the ankle joint disease, and double arthroctomy of elbows at age of ten to eleven. Twelve years ago lupus commenced in nostrils and spread with some rapidity to face and forehead. In spite of various treatment the disease progressed, and the following was condition when on March 26th last I commenced treatment with urea. One large ulcer occupied an area, around which I will trace an imaginary line commencing at the centre of hair of forehead to a point half an inch above the outer end of each eyebrow, then inwards along the upper border of the eyebrows to a point above the root of the nose. The nasal bones had necrosed and come away, leaving a round hole leading into nasal cavity. Ulceration existed on both cheeks, and the left lower eyelid had gone. From the outer edge of the ulcer on one cheek to a corresponding point on the other measured six and a half inches. In the centre of the face was a bridge tissue, representing remains of the nose covered with epithelium. Below this was another irregular hole where had been the nostrils. Ulceration was present over the area where the upper lip had existed, most of this having disappeared. The edges of these large ulcers were very much raised, irregular nodules composed of chestnut-coloured apple-jelly-like matter, sharp cut towards the ulcer and gradually sloping down towards healthy skin. Some of the nodules stood three-sixteenths to a quarter of an inch above the level of the ulcer. Inside the nose one large cavity existed, the septum, part of the ethmoid and most of the turbinated bones having disappeared. The walls of this cavity were in a similar condition of ulceration to the external parts. The granulations over all the ulcers were unhealthy, and showed no signs of healing except at the parts most distant to the spreading edge. Here such attempts were very feeble. There was very much discharge of a thin, purulent character. So much collected in the naso-pharynx that the patient almost choked every morning before he could get rid of this. The general condition was poor and the man most miserable. Treatment was begun on March 25th, when 20 grs. urea t.d.s. was prescribed. By June 11th the nodules on temples had disappeared, and that on lip was disappearing. At the present time the forehead is practically healed, a small sore on the lip, owing to the local application not suiting it, formed, and has not yet healed again. The local application during the whole treatment was not changed, nor was patient's diet or way of living. His diet was chiefly potatoes, and had been for years. His mode of living was to keep in one room all day, and come out to sell papers in the evening.

CASE 2.—Man, *æt.* 30. Father died of phthisis. Nine years ago lupus commenced on right side of face, and gradually spread round to under chin, healing behind as it travelled, except at junction of lobule of ear with face. Four years ago left side of nose and face was attacked. The patient also developed strumous dacrylitis in second finger of right hand four years ago, this eventually healed with deformity, leaving a tuberculous dermatitis on back of right hand. June 24th. Urea grs. 30, t.d.s., was prescribed. The patches were then all raised and nodular and covered with scales and scabs, under which, on removal, was the jelly-like granulation tissue. The most marked patch was on the left side of nose, as big as half-a-crown. July 2nd. Very great improvement. The raised areas are level at the circumferences with surrounding skin, and are less red. Sensation in them has improved. The scabs are now limited to central part. Urea continued. July 9th. The skin, which was stiff and hard where it was affected, is getting pliable and softer. The patches of lupus are melting away. Patient is still under treatment.

CASE 3.—A man, *æt.* 22. Glands both groins began to swell a month ago. No apparent cause found. One gland on left, softening in centre, opened, and typical tuberculous caseous gland substance scraped out. Other glands enlarged, and on the right, one softened. Urea grs. 30 t.d.s., increased gradually to grs. 40 t.d.s. The patient, who looked poor and thin, rapidly improved, and the glands did remarkably well; the one that was first scraped out healed in three weeks, the other

at work in three weeks. Diet and general conditions fairly good.

CASE 4.—Woman, *æt.* 30, married. Family history of phthisis. Glands enlarged for fifteen years left side of neck. Operated on four years ago, and again by myself six months ago, when I removed glands from base of skull to clavicle. Recurred two months ago, just under angle of jaw, and when put on urea, there was a large mass of glands in this situation pushing out the skin and looking as if they must come through. After urea grs. 35 t.d.s. for six weeks, these glands have almost disappeared, and the woman is better in every respect. Still under treatment. Diet and conditions fair.

CASE 5.—Boy, *æt.* 15. History of phthisis. History of two months pain and weakness in right elbow. The joint was almost fixed at a right angle, and very painful. All the hollows were filled with typical soft tuberculous granulation tissue in the synovial membrane. Wasting of forearm half an inch. No history of injury. July 2nd.—After urea gr. xx t.d.s., and rest on a splint for ten days, patient was much improved. Could flex forearm, so that fingers could touch shoulder. Extension not so good. Pronation on arm and supination nearly perfect. All these movements done without pain. The swelling about the elbow was very much diminished. July 9th.—Swelling about elbow has disappeared altogether. Movements as before, but extension from full flexion to within forty-five degrees of full extension. Still under treatment. Diet and conditions fair. Urea 1·4 per cent. Average total quantity urine, 36 ozs.

CASE 6.—Girl, *æt.* 18. History of phthisis on mother's side. Lupus commenced two years ago in nostrils. Glands enlarged in both submaxillary regions and broke leaving ulcers. In the left nostril only the orifice could be seen, owing to granulations of jelly-like material and swelling of the parts. There was a typical patch of lupus about the left part of the upper lip and cheek. July 9th. After a month with urea grs. xxx. t.d.s. the left nostril can be examined with ease and the septum seen to be occupied by a healthy granulating ulcer. The lupus on the lip and cheek have all faded away, and the tuberculous ulcers in the submaxillary regions have healed. Patient under treatment. Diet and general conditions poor.

CASE 7.—Patient, *æt.* 22. Many enlarged glands on right side of neck, together with large tuberculous abscess under sterno-mastoid from the softening of one. The abscess was opened, washed out and stitched up, no drain being used. In six weeks' time, after an average dose of 30 grs. urea three times a day, the whole of these enlarged glands had entirely disappeared. There was a history of phthisis in this case, but diet and general conditions were very good.

In all other tuberculous cases in which I have given urea myself I am having, or have had, good results. Not a single untoward symptom has arisen; on the contrary, the action has evidently been in many cases that of a nervous tonic.

In conclusion, I will draw attention to the fact that Dr. Harper has already laid stress in the *Lancet* on the facts that the tubercle bacillus in the laboratory grows best on media that are of low nitrogenous value, and that in the lower animals it attacks the herbivorous rather than the carnivorous.

The cow is an interesting animal, from this point of view, as it is the animal more often attacked by tuberculosis than any other. Here we have a large amount of energy expended in procuring a sufficiency of nitrogen from herbs and a large loss daily in proportion in the casein of milk. This process of extraction of nitrogen goes on far beyond the ordinary period of lactation. It would seem that there may well be a relationship between nitrogenous absorption, assimilation, and elimination, and the tubercle bacillus in this case. I sincerely hope that elaborate experiments will be made with urea in the near future, and that it will be widely tried in all forms of tuberculosis. Personally, I believe that Dr. Harper's discovery will lead to a revolution in the treatment of this disease, and that many cases which have been considered hopeless in the past will be cured in the future.

## THE GENERAL MEDICAL COUNCIL.

### ADDRESSES BY THE CANDIDATES FOR THE NEXT ELECTION.

ADDRESSES by Mr. G. Brown, Dr. J. G. Glover, Mr. Victor Horsley, Mr. George Jackson, and Dr. S. Woodcock were delivered before a meeting convened by Dr. G. Horder which took place on August 2nd, by permission of the British Medical Association, at the Ladies' College, Cheltenham. The chair was occupied by Dr. Horder, who invited Mr. George Brown to speak first.

Mr. GEORGE BROWN said he did not regard the meeting as one that can come to any definite conclusion by way of deciding as to who should or should not be recommended to the constituency as those who should be selected for representation. He was not prepared to give an account of his stewardship then and there, but hoped that he had succeeded in satisfying those who had placed him in that position. Under these circumstances he hoped it would be agreeable to the medical men of England and Wales to give him their votes again. Having put his hand to the plough he had no intention of turning back, though, as a general practitioner, it was undoubtedly a great tax upon one's time. He had opposed the Midwives Bill for ten years on the principle that he did not believe that a partially educated woman after three months education should be given a diploma or licence to practice midwifery, and be allowed to use dangerous drugs which they are advised to do by those who lecture to them. At a meeting at Manchester he had said that if he remained on the Council for three years without something being done he would resign his seat. This he had not done because he found that their sending as direct representatives to the Council men from their own body had a considerable effect and influence on some important matters, for instance, more stringent regulations with regard to the suppression of unqualified practice. Since the last election much had been done by the Council in prohibiting unqualified assistants, and the effect of that had been of a most satisfactory kind as evidenced by the higher salaries that were obtained, and a great deal has been accomplished also in respect of preliminary education, although the effects were not very apparent yet, but the regulations are agreed to which will have a great influence indeed in the future admission of candidates to the medical profession. Referring to the case of the late Kingsley Hunter, he said that he could not acquit himself from all blame in that matter, but the fact was that Mr. Hunter's name was dovetailed in a list of unqualified men and no one knew that he possessed a qualification otherwise he would not have consented to his prosecution. He certainly thought they ought to have had a summary of the evidence, but then if he had applied for such he would have been told he was wasting the time of the Council as he had been told before. He complained that more than once when he had a motion down on the paper someone popped up and moved the previous question which unfortunately was invariably carried. That however did not occur now. He said that his colleague, Mr. Horsley, and himself had worked very harmoniously and happily together during the time we have been on the Council, and if he had the happiness and honour to again represent them on the Council he would have the opportunity of continuing to work with him. He hoped they would send three representatives who would work harmoniously hand in hand, because it weakened direct representation when one voted on one side and one on the other.

Mr. A. B. RITCHIE (Manchester) asked if Mr. George Brown believed it probable that the practice of midwives could be restricted by legislation, so as to make the attendance of a medical man compulsory in cases of confinement; also what policy did he support in connection with such legislation as was threatened?

Mr. GEORGE BROWN said he would oppose the present Bill *in toto*. He was in favour of a Bill for the better training of nurses by public bodies for poor people.

Mr. A. B. RITCHIE said that Mr. Brown had not answered his questions, and Mr. R. H. WOLSTENHOLE (Manchester) wanted to know if Mr. Brown supported the Medical Guild Scheme. To which Mr. G. BROWN replied that the scheme was on the lines that he would support.

Mr. J. S. WHITAKER (Great Yarmouth) said it would be more satisfactory if Mr. Brown answered Mr. Ritchie's question whether he believed that it was reasonable or possible to expect the Legislature to pass any measure requiring every obstetric case to be attended by a medical practitioner.

As Mr. George Brown did not quite understand the question in that direct way, the CHAIRMAN read out the question to Mr. Brown, who said that he was sure the Legislature would do nothing of the kind.

Dr. J. G. GLOVER expressed the hope that they would have at the next election a larger vote of the profession than on any previous occasion. It will be impossible to get any real addition to direct representation if three-fourths of the profession stand aloof and left the election to groups and small numbers. A very serious blow was inflicted on direct representation after the last election, when one of the gentlemen elected, after clamouring for a seat, left the Council without even waiting to discuss the main question he was supposed to understand, and for the solution of which he was chosen. He had enjoyed their confidence for fifteen years—that is, for three separate quinquennial periods—and he was asking them once more to re-elect him. He pointed out that few members of the Council had seen more of its working; few had had a larger experience of its principal committees; few knew better what the Council could do and what it could not do than himself. The Council was not perfect—it was too large; it wanted reconstruction, and it wanted larger powers; but in his opinion it had great powers for good even in its present form, and he saw no immediate chance of it being materially altered. It had done very much already and might do much more, both for the public and the profession—for medical education, and for the purity and dignity of the medical profession, which are of enormous consequence to the public. And he believed sincerely that for those ends the presence

on the Council of general practitioners—men acquainted with general practice, with its problems, its difficulties, its grievances—were essential and would be acceptable to the Council. Even those who differed from him on the matter of the midwives question would allow that I have never shirked the question, and that I had consistently held that some regulation of midwives' practice was urgently required, and could scarcely be had without legislation. His support will only be given to a Midwives' Bill on two or three very strict and well-defined conditions. First, that the practice of unlicensed midwives be stopped and penalised; and, secondly, that the midwife should be required, on the occurrence of any irregularity or abnormality of mother or child, to apply to a registered medical practitioner, thus placing her in a distinct, non-medical, subordinate position. He had a third condition, to which he attached much importance, though he had not been able here, as in the other points, to get the Medical Council to agree with him—viz., that the local sanitary authority of each district should be required to pay medical men a reasonable fee (not less than a guinea) when appealed to by the midwife. He wished to abolish the existing untrained, ignorant midwife—the Sarah Gamp—believing her to be dangerous and deadly to poor lying-in women, who are entitled to the greatest consideration; also to abolish the unauthorised function of the London Obstetrical Society in giving certificates to midwives. He was no party to blaming the Society for its efforts to raise the character of midwives and to give them some training, and he was quite sure that the Medical Council would find itself without public support if it sought to abolish this function of the Society, without seeing how the function was to be assigned to some other body. The only way, and the proper way, to get rid of the irregular and unauthorised action of the London Obstetrical Society would be to create a Board, acting under law, to do what it is doing, and for which it has in time past had the approval of the public and the tacit approval of the Medical Council. He felt convinced that such legislation would come to pass, and that it would be done independently of the medical profession if it loses the chance of shaping it and controlling and regulating the practice of midwives. In this matter as in some others, Mr. Brown had posed as the saviour of the medical profession. He has a medical paper all to himself—which in the interval of elections underwent a sort of hibernation, and just before the great event, came to life again and demonstrated to its readers that he (the speaker) was the great sinner the Jonah—and that he (Mr. Brown) was the man to elect to represent the profession. Yet, during the last five years Mr. Brown had never once in all the midwifery discussions moved the Council to declare that it disapproved of all such attempts at legislation. But he led his followers to think that he was going to do so, and that some great change was going to occur. He (Dr. Glover) would warn them that such a change could occur without the Council stultifying itself. Mr. Brown would probably not get a seconder as had happened on a recent occasion. The midwives question after all was only one of a score or a hundred questions that have to be considered by the Medical Council, which was *par excellence* a Council of Medical Education, and this must have for its basis a sound preliminary education. He had tried to do his duty as their representative on this question, and in the very first Session after his election to the Council he had drawn attention to the want of practical teaching in clinical and therapeutical subjects and of examinations in such subjects. The defect was admitted; he was put on the Education Committee, and the resolution he had proposed had been fruitful of good. Passing on to another topic he said that the principle of a Conciliation Board had been approved by a Committee of the Council of the British Medical Association, and there was reason to hope much from the application of it in the improvement of the position and power of the medical profession in relation to the great Friendly Societies. The Council had to discourage degrading and unprofessional modes of promoting practice—especially advertising and touting. He had proposed a resolution meant to discourage these practices, which had been very effective where the evidence of such practices and of the doctor's knowledge of them was sufficient. One or two large insurance companies with medical aid business had given up the business, and several medical officers had resigned their positions under this clause. Mr. Brown moved the Council to something more drastic and did not get a seconder. Such conduct was of no service to the profession; it wasted the Council's time and money, and placed it in an undignified position. Dr. Glover then commented on the present position of the reform of death certificates, and deplored the friction between the Royal Colleges and the Council which he hoped soon to be settled. In regard to the finances of the Council he believed that with some reforms in the conduct of their discussions the ordinary income of the Council would still suffice to meet its expenditure, and he was therefore opposed to an annual tax. He defended the Council against the charge of inertia, observing that the changes which are taking place in the profession—in its curriculum—in its education—in the public estimate of it—and in the State estimate of it were enormous, and in some aspects serious. He asked them to remember that as regards the election it was not the Medical Council that was on its trial so much as direct representation itself.

Mr. VICTOR HORSLEY said he was hopeful that the meeting would be the precursor of many similar meetings, and that it would be a fixture at the annual meetings of the Association. With regard to his views on the midwifery question he still held that registration of existing and prospective midwives was necessary and should be insisted on by the Legislature. Their duty as members of the General Medical Council was to see as far as they could that the Government did not lend their support to any measure which did not embrace the essential points given in detail in the Minutes of the General Medical Council. He complained that although the General Medical Council was practically a sub-department of the Central Government, its head being the Privy Council, which was presided over by the Duke of Devonshire, the Privy Council had during the last ten months treated the General Medical Council with superlative contempt. They would find all the facts in the Minutes. It was ridiculous for them to consider that as a sub-department of the Government they could through their President, or through anyone else, influence the Privy Council pri-

vately. The only way to do it was through the voice of the profession. He believed that they would get this power, but in the meantime the General Medical Council was unable to do what it wished to do in the matter. He personally was responsible for endeavouring to send up a protest to the Privy Council against its behaviour towards them as its sub-department. Dr. MacAlister, however, opposed him, and succeeded very easily in persuading the Council, so that no protest was sent. Another instance of such contemptuous action on the part of the Privy Council occurred in respect of reciprocity of practice in Italy when the Privy Council passed an order entirely disregarding their views as a Council.

As regards the work of the Council in education the matter of the Colleges was really a very grave question. The step taken by the Royal Colleges was subversive of the present five years' curriculum and of the best interests of the medical profession, and it would ruin students' registration. The representative of the Royal College of Physicians, which body was tottering to financial ruin, did not hesitate to state in the Council, and his speech unfortunately made a most favourable impression on the Council as a whole, that he was willing to ruin students' registration simply to carry out the wishes of his College. He warned them not to enter into any compromise on this matter, for any yielding would lead to an irreparable injury to the medical profession. As regards preliminary professional education headway was being made in this matter by the Council itself, quite irrespective of this step taken by the Royal Colleges. The question of education was considered with that of the one-portal system. By the constitution of the General Medical Council it was unable to receive a scheme for the one-portal system, for the Council was composed of commercially competing bodies, and was thus really unfit to control medical education. He then discussed the necessity for a Medical Act Amendment Bill. They had swept away the men who were bitterly hostile to the profession. It has caused hard words and some misunderstanding, but the men had gone, and in their place they had a younger set of men, among them deans of medical schools who are keenly interested in general medical education. These men are men to whom one would appeal with reason, and the outlook for the Medical Act Amendment Bill is better. But the body of the General Medical Council consider that such a Bill should come from the British Medical Association, and he was willing to accept that position. He suggested that they should meet them, that the British Medical Association should go on with the work of the Parliamentary Bills Sub-Committee and bring to the General Medical Council the Bill that they asked for. In such a Bill the mention of unqualified practice should take first place, but as the price of the purchase of that, of course, the House of Commons will require what we also require, that the constitution of the Council shall be changed, and that it should be deprived of its corporate body, that is to say its commercial character, so that it shall be made a representative Council, and if the House of Commons demanded it there should be an addition of one or two more Crown members. There must be a bargain, and they must give something in return if they were to get anything out of the House of Commons. He had left his next point to the last because he believed it was a ever by means of which they would reform the General Medical Council, viz., the question of money, which is at the bottom of most things. They had now got to the bottom of the pocket of the Council, and the Council was in a bad way and might find it necessary to go to the House of Commons and ask for some change in legislation which it could put into operation in order that it may live. He reviewed his action in exposing the unsoundness of the Council's finances and said that the report proposed as reforms everything that they had been asking for. Among these reforms was the Annual Registration fee. He said that he was a firm believer that the annual registration was a necessity in legislation. An annual registration fee of one pound would give the General Medical Council an income of £30,000 and that was amply sufficient for the Council to be really operative in the interests of the public and the profession. The question of the annual registration fee, which he personally considered a necessity, had never been properly discussed, and as they looked to Manchester as usual for reform, so they looked to the meeting at Manchester to have that point thoroughly threshed out so that we shall know what is the voice of the profession in the matter.

Mr. GEORGE JACKSON (Plymouth) recalled that at a previous election he had polled over 4,000 votes, and had been asked by the Incorporated Practitioners' Association to come forward as a candidate again. In regard to the question of the midwives he said they ought to try and guide legislation so that it shall not be registration of midwives as midwives, but rather as nurses, and I would say that all nurses should be registered. It should be impossible for any woman after just three months training to be turned out as a midwife. He urged that district nurses should be appointed who might give lessons in elementary sanitation and attend to ordinary dressings. The population was not increasing and one woman in fifteen was said to die in her first confinement. At any rate, the mortality was very considerable, and it behooved them to take more care of their population-producing people, to take more care of the mothers of the country and not allow them to die in this way, and to take more care of the children. He suggested that the British Medical Association should introduce a Bill into Parliament on the lines indicated on the "Medical Guild Quarterly," and that there should be a regular system of nurses that should have two to three years training before they were allowed to have anything to do with nursing, as a sufficient training was necessary so as to thoroughly drill the nurses in their work, because, if taught only for a limited time, the nurses relapsed into careless ways. He would be in favour of more direct representatives and of cutting up the country into smaller districts. The General Medical Council would thus be able to promote legislation favourable to the profession and to the country at large. Quacks, who practised under the name of aurists, oculists, should be prosecuted. It would be a good plan if every medical man had to pay a small annual sum each year which would then enable the Council to act. The examination for the entrance to the medical profession should be raised. Another important point is that a bill should be introduced into Parliament for the better registration of deaths, because of the enormous

number of uncertified deaths. Still, births also should be registered. He could not claim personal experience like the present representatives, but, if elected, he would carry out the duties as far as he could.

Dr. S. WOODCOCK, J.P. (Manchester), seemed doubtful whether or not he spoke as a candidate. He maintained that they were entitled to a representative from the north of England, and other places than London should have some share in representation. With regard to the midwives' question he had never been in favour of initiating legislation on this question. He objected to self-elected men arrogating to themselves the right of giving certificates to women, and he had assisted in elaborating a Bill in which two or three principal things were aimed at, limiting the function of the registered midwifery nurse in a definite way. This Bill, however, was to be put in only in order that it should not be said that they had nothing to suggest. He considered that to insist on a medical man being called in in every case of confinement was impracticable. With regard to the attitude of the present Government he said that with all their efforts they had never been able to get at the President of the Privy Council, who had invariably refused to receive a deputation. On the other hand, the promoters of the Midwives Bill had had no difficulty, and they were encouraged by him to go on, and when a vacancy occurred in the General Medical Council of a Crown nominee the appointment was given to the man through whose efforts more than anybody else the first and the worst Registration Bill was brought forward. With regard to the Medical Guild Bill, he did not disapprove of it, but he wanted something to be done in his lifetime. Speaking generally he approved of the attitude and policy of Mr. Horsley, and he agreed with him on this midwives' question. He was not supporting the measure in favour of the registration of midwives. He had also taken some part in attempting to draft a Medical Act Amendments Bill, and there he had sufficiently indicated his opinion in regard to the representatives of the corporate bodies. These should be elected by the licentiates and members of those bodies. He thought they should aim at having the one-portal system. If the Council was paralysed for funds we should go to Parliament and get permission to have an annual registration fee. He knew something of the work of general practice, and had had some experience in public life, and if the medical profession thought he had the ability and the tact to represent them sufficiently well he was prepared to place himself at their service.

Mr. BIRCHIE said after the speeches they had heard the midwives question must be dropped out of that election.

Mr. G. H. BROADBENT (Manchester) said that he thought just the opposite because it was most essential.

The CHAIRMAN then asked the candidates: Did they believe it probable that the practice of midwives will be restricted by legislation so as to make the attendance of a medical man compulsory in cases of confinement, to which they answered, No.

Dr. GLOVER said in reply to Mr. A. Cox, of Gateshead, that he voted for the present form of certificate issued by the London Obstetrical Society, and he would continue his present attitude until some legal body was provided to look after that business.

Dr. MAJOR GREENWOOD remarked that the Council had made the Obstetrical Society alter the diploma issued to midwives into a certificate. What was it that led those who held certificates to go on using the term L.O.S. That was the most important point and that was omitted by the Council.

Mr. WOLSTENHOLME asked Dr. GLOVER if he had afforded Mr. Horsley assistance when the Chairman of the Council refused Mr. Horsley access to the documents.

Dr. GLOVER said that he did not remember the circumstances about the first resolution dealing with the documents. The ultimate resolution, however, by which the documents were accessible, was moved by him. He explained that he had no other object than to secure first the care of the documents, and secondly, the right and convenience of members in the use of them. The present resolution of the Council was drawn up by him in place of the first one, which, though he supported, was not quite satisfactory.

Dr. WOLSTENHOLME said the scheme of the Royal Colleges appeared to reduce the medical curriculum to four years. Dr. Glover had spoken of a *modus vivendi*, was that to prevent the five years' course being cut down to four?

Dr. GLOVER replied that he had no intention of disturbing the five years' course, and there was not one instance in which the Colleges had accepted less than a five years curriculum. They included in that curriculum one year passed at a preliminary educational institution approved by them.

Mr. WOLSTENHOLME then wanted to know if Dr. Glover agreed to that.

Dr. GLOVER said that he agreed with that till the Council had power to interfere with the legal rights of the Colleges.

Mr. WOLSTENHOLME then demanded from Mr. Horsley whether he had had any difficulty in inspecting the documents of the Council, whether he had been thwarted in that attempt, and whether Dr. Glover had properly supported him. Also was Mr. Horsley in favour of the *modus vivendi*.

Mr. HORSLEY: In regard to the first Session when the question of the documents came up, he saw when he made his protest he was opposed by Dr. Glover so strongly that actually he could not obtain a fair hearing, and during the whole of that week's work he was looked upon as a kind of outcast for having endeavoured to disorderly interrupt the Chairman. That was the state of affairs, but he carried his point at the next Session. He admitted that it was on Dr. Glover's motion that the documents are now open for inspection. With regard to the *modus vivendi* with the Colleges, he thought that if the matter were brought before the Courts the Courts would have to say both parties were in the right, so he intended to resist any attempt to spend the money of the profession in going to law in this matter. There is no possible *modus vivendi*. If the Council chose to succumb to the Colleges, that was possible, and unless the direct representatives would say, with the voice of the profession behind them, that the Council shall adhere to its former position, a very grave injury would be done to the medical profession.

After some further questions and remarks, the proceedings terminated with a vote of thanks to the Chairman.

## Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, August 10th, 1901.

### SANGUINAL KREWEL.

A PARTICULAR mania for new drugs with physical and chemical demonstrations has now overtaken the minds of the Austrian medical world. Diagnosis and prognosis was formerly the chief end of all medical labour in the wards with bacterial examination to confirm the prophecies, and there the case ended. Now things have changed. In every ward you enter experiments are proceeding with some new drug which has given rise to a restlessness for novelty which is constantly supplied by the proprietary vendor, who is ever ready to act on the slightest suggestion.

Sanguinal krewel is another of those hæmatic preparations recently launched on the market as a ferri albuminous combination. It contains the iron in its native form, and represents 10 per cent. of hæmoglobin, 44 per cent. of peptonised muscle, and 46 per cent. of the blood salts which Bunge affirms is the most important constituent to be supplied in all cases of anæmia.

Gerber, in Prof. Neusser's wards, has recently been testing the efficacy of sanguinal krewel in chlorosis as a standard test for anæmia. Many experiments have been conducted with it in neurasthenia, rachitis, scrofula, nephritis, tuberculosis, and syphilis with the greatest success, but in chlorosis, where Boerhave has affirmed that "*Nihil in hoc casu plus conducit quam Chalybis*" has not authoritatively been put on record, which Gerber has endeavoured to supply. He affirms that he has not attempted to interfere with the question still under controversy, whether iron supplies a want or merely stimulates the hæmato-potic apparatus, but contents himself with the physiological and clinical results with actual examinations of the blood. No effort was made to discover whether the albuminoid compound was broken up as a chloride sulphate or nitrate, as it is now taken for established that the drug is absorbed as an albuminoid. In addition to this sanguinal krewel combines in itself the constituents of the other theory that the salts of the blood are at fault, which is supported by the fact that manganese and fresh peptonised muscles, which alone is potent in the regeneration of nuclein, lecithin and fat are all present, thus increasing the number of the red blood corpuscles and amount of hæmoglobin in the sanguineous fluid.

In all the cases experimented on the clinical facts, both objective and subjective, were excellent. The body weight and general appearance was improved, while the dyspnoea and palpitation were removed in a very short time.

To prove this he quotes the case of a young woman, æt. 20, factory worker, who had suffered for three years from chlorosis, for which she had used Blaud's pill, ferrum, &c., with varying degrees of success. Still she complained of general malaise, difficulty in breathing, rigors, palpitation, pain at the cardiac end of the stomach, menses irregular, and dysmenorrhœa.

On February 10th pil sanguinal, three per day, was administered. Hæmoglobin, 80 per cent.; red blood corpuscles, 24,80,000; colour index, 0.4; white cor-

pucles, 4,320; body weight, 52½ kilos, or 115.5 lbs.; poikilocytosis, microcytosis, and blood-plates.

On March 17th the hæmoglobin was 60 per cent.; red blood corpuscles, 5,240,000; colour index, 0.6; white blood corpuscles, 4,800; body weight, 55½ kilos, or 121.2 lbs.

The second case was a housemaid, æt. 16, who for the last half year had suffered from severe headache, difficulty in breathing, vertigo, rushing in the ears, constipation, and pain in the stomach. The skin and mucous membrane were pale; systolic murmurs over mitral and pulmonary areas; cardiac area diminished; spleen imperceptible, no fever, no albumin in urine or œdema anywhere.

On February 25th 25 per cent. hæmoglobin, red blood corpuscles, 2,287,000; colour index, 0.6; white blood corpuscles, 6,400; body weight, 54 kilos. After commencing with three pills of sanguinal it was increased to four pills a day on March 4th, and on March 26th the hæmoglobin was 45 per cent.; red blood corpuscles, 4,200,000; colour index, 0.6; white corpuscles, 5,960; body weight, 58 kilos, or 127 lbs.; while the blood corpuscle as in the former case had resumed a normal appearance.

Fifteen other cases related gave somewhat similar results, which speaks favourably for sanguinal krewel as a hæmapoetic drug.

#### HOFBATH BARON WIEDERHOFER.

Another of Vienna's lights have ceased to burn in the person of Professor Wiederhofer, who has long enjoyed the imperial sunshine of the palace, being the favoured attendant and special adviser in the Imperial family.

He was born at Weyer, in Ems, Upper Austria, 1832, and qualified in medicine at Vienna in 1856. He commenced as assistant under Professor Mayer, in the Children's Hospital, and soon after was appointed second in the Vienna Orphanage. In 1862 he was made extraordinary professor, and in 1884 ordinary professor.

It was in 1863 he was appointed private attendant to the Kaiser's family, since which he has endeared himself to the head of the monarchy in Austria.

As teacher and examiner, Wiederhofer was respected as a highly-cultivated and learned authority in pædiatrics. Students and colleagues were regularly found crowding his class-room, which was never large enough for the number that desired places.

Two years ago he was seized with an apoplectic fit, from which he recovered, but last winter another repetition paralysed the centre of speech. To recover strength he was transferred to Ischl, where he died, under the solicitous care of the Kaiser and his family.

## The Operating Theatres.

### KING'S COLLEGE HOSPITAL.

EXCISION OF LOWER JAW FOR SARCOMA (?).—Mr. CARELESS operated on a girl, æt. 21, who had been the subject of a large swelling of the right side of the mandible for some months. The case had been under the care of Dr. Bateman, of Richmond, and the tumour had increased considerably. Dr. Bateman had previously made an exploratory incision demonstrating that the mass was mainly solid, but with bony foci scattered through it, and that it was exceedingly vascular.

The mass had grown since that exploration, but not very rapidly; it was of a hard consistence, but it felt more like cartilage than bone, there being a slight "give" about it; the margins were very sharply defined, and the mass projected mainly on the outer side, encroaching but little on the mouth. Mr. Carless expressed the opinion that the tumour was of a fibro-cystic type, or, as it has been termed by Mr. Bland-Sutton, an epithelial odontome. The patient having been anaesthetised, an incision was made from the lobule of the ear behind the tumour mass to a point half an inch behind and external to the symphysis menti, practically running along the lower border of the jaw. In the centre this cut was deepened so as to expose the tumour; the fibres of the masseter were firmly incorporated with the outer wall, which was opened through, exposing a tumour mass partly infiltrated with bone, and exceedingly vascular. The finger was used to break down the mass and define its structure and limits, and as it was found that the growth occupied nearly the whole of the vertical ramus, and also the horizontal ramus as far forwards as the second molar, it was obvious the only way to deal with it was to excise this portion of the mandible. The cheek tissues were therefore reflected off the outer wall of the tumour, but the greater portion of the masseter had to be left attached to it. The horizontal ramus was cleared and a section made with the saw between the first and second molar teeth. It was subsequently found that the inner aspect of the jaw had been slightly encroached on by the tumour in front of this line, therefore a second section was made immediately behind the canine tooth. The tumour mass was then enucleated; this was a matter of some difficulty owing partly to the hæmorrhage, partly to the fact that the mass broke down, the outer portion of it breaking away with a part of the horizontal ramus, leaving behind a deep soft portion, which extended into the pterygoid region and upwards, along the temporal tendon as far as the great wing of the sphenoid. Both the coronoid process and condyle were removed, the growth having encroached to within a very short distance of them. The whole dissection was made with a very small opening in the mouth, really not more than three-quarters of an inch, as a number of the teeth on that side had been removed previously. The bleeding having been stopped, an attempt was made to close the wound in the mucous membrane by the introduction of stitches, and the external wound was sutured in the usual way, a drainage tube being left in. The tumour was as large as a good sized orange, and it had destroyed the greater portion of the jaw. The slowness of the growth and the sharp definition of its borders were points in favour of its being simple and not malignant in nature. Mr. Carless emphasised the desirability of not laying the buccal cavity more freely open than was possible, inasmuch as by this means it was easier to prevent the wound becoming septic; suturing up the mucous membrane, he said, also had this object in view. Unfortunately this happy result was not attained as the wound subsequently became infected, but not seriously.

### TOTTENHAM HOSPITAL.

HYSTERECTOMY FOR MYOMA.—Dr. ARTHUR GILES operated on a single woman, æt. about 40, who had suffered for some time from pressure symptoms due to the presence of a large uterine myoma. Dr. Giles had



performed an operation for myoma uteri on the patient's sister three years ago. In the present case the patient was seen about two months before the operation, when she complained of pelvic pain, frequency of micturition, and menorrhagia. The last symptom was not, however, very pronounced. On examination the cavity of the pelvis was found occupied by a hard large mass which depressed the pouch of Douglas and extended laterally, so that it appeared to invade both broad ligaments. The cervix was drawn high up behind the pubes, and there was scarcely room for the examining finger in the vagina between the tumour behind and the pubes in front. In view of the form of the tumour as felt through the vagina, and of the fact that hæmorrhage was not a conspicuous feature in the case, it was surmised that the growth was mainly sub-peritoneal with lateral extensions into the broad ligaments. Operation was advised on account of the pressure exercised by the swelling. The patient readily agreed to operation, but desired to wait until the reopening of the Chelsea Hospital for Women where her sister's operation had taken place. As there appeared to be no immediate urgency this was arranged. Some weeks later, however, she had retention of urine on several occasions, and it was decided to operate without delay. From the character of the growth as diagnosed a difficult operation was anticipated, but on opening the abdomen and raising the tumour out of the pelvis the operator was agreeably surprised to find that the cervix and broad ligaments were in no way involved, and the operation proved to be a simple and straightforward one, the ordinary supra-vaginal hysterectomy being performed. The main portion of the growth was the size of a foetal head, it originated from the posterior aspect of the fundus and had extended downwards in its growth till it had occupied practically the whole of the available space in the true pelvis of the cavity of which it formed a fairly perfect cast. A marked flattening of the left posterior border indicated the position of the rectum. The body of the uterus was studded anteriorly with several small growths resembling new potatoes, but its cavity had not become involved. In the toppling over backwards of the tumour the cervix had become gradually drawn up anteriorly. The frequency of micturition and the subsequent retention of urine from which the patient suffered were readily accounted for by the anatomical conditions present. Dr. Giles said that there were three leading indications for surgical intervention in cases of myoma:—1. Hæmorrhage; 2. Degenerative changes, and 3. Pressure symptoms. One or more of these might be present in the same case. In the present instance operation was undertaken on the third indication. It was evident, he pointed out, that had the case been left alone the pressure effects must have been grave; those most to be feared would have been changes in the bladder and kidneys; pain also must necessarily have become very severe. Diagnosis of the precise condition present was practically impossible, as the pelvis was so completely filled up; the subperitoneal character of the growth was indeed suspected on the grounds given before the operation, but the important matter from the point of view of operative manipulation, whether or not the lower zone of the uterus and the broad ligaments were free from growth, could only be determined after the tumour was exposed. He called special attention to the

characteristic cast of the pelvis formed by the tumour, this, he said, was not often seen except in the case of cervical myomata.

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## The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, AUGUST 14, 1901.

### THE CHOICE OF DIRECT REPRESENTATIVES.

THE meeting at Cheltenham last week, of which we publish a report elsewhere, brings the approaching election of direct representatives to the fore. We commend this report to the notice of our readers, at any rate of those who are interested in the election of representatives for England. From it they may glean an idea of the present condition of medical politics, and form an opinion as to the points to be borne in mind in voting for candidates to represent them on the General Medical Council when the present mandates have expired by effluxion of time. There seems to be a general opinion that the time has come for the infusion of new blood. Although there are obvious advantages in selecting men who are closely in touch with the wants and aspirations of the great mass of general practitioners, that is to say, men who are themselves general practitioners, this alone should not be deemed a sufficient qualification for selection. It is necessary that the direct representative should be in a position to command attention and respect, either in virtue of his professional status or by reason of his intelligence and familiarity with the problems in the solution of which he will have to take a more or less prominent part. Mere amiability of character and affability, though they may conduce to harmonious relations with the other members of Council, are not qualities calculated to the effective discharge of the responsible duties which the direct representative is required to discharge. Then, too, the representative should be a man of superior education, in order that he may hold his own in a society of educated gentlemen. In so far as these

qualities, or the more desirable among them, are common to all the candidates some further test must be applied. Clearly it would not be prudent at the present juncture to make the much-debated midwives' legislation the touchstone. There is reason to suppose that the general feeling in the profession is opposed to legislation in the direction of providing for the registration of midwives, and this feeling, no doubt, is mainly influenced by the view that to dub midwives women who have received at most a very perfunctory training in the art is to invite, nay, to create, a detestable form of competition. Nevertheless, it is well to recognise that something has to be done, and the most becoming, as well as the most tactful, attitude for medical men to adopt would be to use their influence to secure the introduction of clauses providing for adequate medical control. By opposing legislative proposals tooth and nail, without presenting alternative proposals, we should simply play into the hands of those who foster the measure, especially as the latter have the advantage of Government support. But there are many other questions before the profession which require to be dealt with. There is the question of Council reform, as to which we must require very explicit assurances on the part of candidates. It is idle to clamour for additional direct representation so long as not more than a fraction of voters take the trouble to avail themselves of the privilege of voting; but we do want the Council to take a wider view of its duties towards the profession and to obtain such additional powers as may be required to enable it to fulfil its functions in purifying the *Register*, and in suppressing the irregular practice of medicine. The finances of the Council are in a most unsatisfactory condition, and we are face to face with the necessity of providing additional funds, possibly by the imposition of an annual tax on registered practitioners. We agree with Mr. Horsley that such payment would in many ways add to the influence of the profession on the Council and of the Council on the public. Lastly, there is the question of the standard of preliminary education, which continues to furnish material for copious discussion without making much progress. The time is not yet ripe for us to discuss the merits of the individual candidates upon whose utterances we shall ponder.

#### "CHRONIC HARMLESS LUNATICS."

THE question as to how the numerous "chronic harmless lunatics," as they are officially termed, which are distributed through Irish workhouses, are to be provided for in a manner which will satisfy modern humanitarian and scientific ideas is one which at the present moment demands solution. Our readers will remember that the Irish Local Government Board issued a circular on February 26th of this year to the Irish County Councils in which they proposed that the latter should consider the following schemes, with the object of determining which would be the most suitable:—

1. To build a separate Auxiliary Asylum for

chronic harmless lunatics with a Resident Medical Superintendent, and at least one assistant medical officer.

2. To add, subject to the Lord Lieutenant's directions, by the erection of buildings less elaborate than the original ones, a new department to an existing Asylum, and to place it under the Resident Medical Superintendent of that Asylum.

3. To acquire and adapt some workhouse or other building, either as a separate Auxiliary Asylum, or, if the Lord Lieutenant should so direct, as a department of some existing Asylum.

The order of merit in which these three schemes will be placed by those who only consider the well-being of the insane, and by the County Councils will probably be very different, and in this opposition of views lies the great danger which awaits all efforts to solve the question of providing adequate accommodation for the chronic insane. If medical superintendents, and philanthropists generally, range themselves on one side, and county councillors on the other, and if neither of them consider that there is any force in the arguments of the other, then the County Council, who hold the purse strings, will carry out whatever scheme is cheapest. If, on the other hand, attempts are not made to force the County Councils into excessive expense, it will probably be found that the latter will agree to whatever scheme unites economy and efficiency. Proof of this is furnished by the action of the Committee of Management of the Down District Asylum and the County Council. In March last, a special joint committee was appointed by these bodies to consider the communication of the Local Government Board, and this committee recommended the adoption of scheme three. Thereupon, the Medical Superintendent addressed a circular letter to the members of the Committee of Management, in which he pointed out the expenses which such a scheme would entail, and the advantages of adding new buildings to the existing asylum—a scheme by which the chronic insane "would have the benefit of the exceptional surroundings of the present asylum, standing in grounds of 170 acres, and well equipped with all adjuncts required by the insane when living in association." And, he stated, further, "that the major portion of the outlay involved in locating the chronic lunatics within the asylum walls would, if his suggestions be adopted, go to render more efficacious those portions of the institution set apart for the acute and curable cases." The immediate result of this letter was that a fresh joint committee was appointed by the Committee of Management and the County Council, and that, at a meeting held in Belfast on July 19th, it was decided to rescind the resolution formerly adopted, and unanimously resolved to recommend the County Council to provide for the insane at present in the workhouses of the county by adding to the accommodation of the existing asylum. We congratulate the County Council on their decision, which in their case and in the case of many similarly situated asylums is at once

the most suitable and the most economical. In our present number we publish a paper by the Resident Medical Superintendent of the Down County Asylum, Dr. M. J. Nolan. In the course of his paper Dr. Nolan elaborates his proposals for dealing with those whom he terms "residual lunatics." At first, we confess, we identified Dr. Nolan's proposition with scheme two of the Local Government Board. This conclusion, however, was incorrect. Dr. Nolan's proposition in brief is as follows:—Transfer the "chronic harmless lunatics" which at present are in workhouses to the county asylum. If there is sufficient existing accommodation for the purpose, so much the better; if not, it must be provided. If there is no room for the extension of the present asylum build an off-shoot to it, not as an "auxiliary," but as "a legitimate branch of the same constitution." Each "chronic harmless lunatic" is then in a position to receive—not the two shilling grant of the auxiliary asylum, but the four shilling grant which is given in the case of the certified lunatic. Furthermore, the expense of the installation and maintenance of a completely new establishment is avoided. And, lastly, the "chronic harmless lunatic" is not condemned—because he is harmless and chronic—to a worse existence than is the acute dangerous lunatic.—Dr. Nolan's scheme at first sight appears to be practical and economical, if the difficulty of obtaining the full capitation grant is removed. It may be, that, "the Act of 1898, with one stroke has practically certified some 4,000 individuals of unsound mind, now located in workhouses . . . and provided that they may be removed elsewhere." Is, however, this certification of a sufficiently practical character to carry with it the full capitation grant of four shillings instead of the grant of two shillings per head which the Local Government Act specifies? That the amount of the latter is absurd few will deny, but it apparently is fixed by the Local Government Act. Here is an opportunity for the Irish members of Parliament.

#### WHAT IS A SANATORIUM?

PUBLIC opinion just now is all in favour of the provision of additional sanatorium accommodation for the phthisical. This wave of opinion has a solid foundation because it embodies the application of the *vis medicatrix naturæ*, but unless carefully supervised it may lead to very undesirable results. The present tendency is to raise a considerable amount of money and then to build a more or less gigantic, and in any event very costly, edifice, in which the unfortunate victims of tuberculosis are to be aggregated. Now there are numerous and weighty reasons why this plan should be modified. Administrative control of an institution of this kind increases out of proportion to its size and, from a bacteriological point of view, nothing could be less desirable than the concentration of large numbers of phthisical patients under one roof or on a limited area. Not only the

cost of construction but also the cost of maintenance increases out of all proportion to the increase of size, and the moral effect on the individual patient of living in the midst of a community of persons similarly afflicted, cannot fail to be the reverse of beneficial. If sanatoria are to be constructed by local authorities or by local philanthropic agencies in any sort of proportion to existing requirements, a much more economical plan will have to be followed. It happens too that economy in this matter is not incompatible with efficiency; indeed, we greatly question whether a multitude of smaller institutions would not on the whole be more beneficial and more easily compassed than a less number of more or less gigantic structures erected at an immense cost. The simplest form, one moreover which is available for many months in the year, is the camp sanatorium. Under intelligent management these could be made and kept as hygienic as the larger buildings; indeed, the problem of complying with sanitary requirements is necessarily much simpler when we are dealing with a comparatively small number of patients than when they are counted by hundreds. There is one point in respect of which, at first sight, the large establishments may appear to offer an advantage, *viz.*, medical supervision. But is this really as important as one is apt to suppose? Except in advanced cases the general principles of treatment are pretty well stereotyped, and can be formulated at the time when the patient is sent to the sanatorium. Obviously such camps must be within a reasonable distance of medical aid, and it might even be well to arrange for daily visits by a neighbouring practitioner who is willing to master the principles of this treatment. If a patient is so ill as to require close medical supervision his place is elsewhere than at a sanatorium, at any rate at a sanatorium of the class under consideration. The fact that the open-air treatment can be made available at comparatively small cost is one which cannot be made too widely known. The number of persons actually suffering from pulmonary tuberculosis is enormous. One of the fundamental principles enunciated at the Congress which has just taken place was that the removal of consumptives belonging to the labouring classes from their insanitary surroundings is indispensable to any success in the endeavour to stem the tide of contagion. Not only is the patient himself placed under conditions favourable to recovery, but by removing him we remove a fertile source of infection from his family, his neighbours, and from the district in which he resides. At the sanatorium he will learn enough of the nature of his disease to recognise and adopt the elementary precautions which, if methodically carried out, prevent his being a source of contamination. This is the sort of education that is required. It may be trusted to produce beneficent effects far and away beyond those of any number of lectures or sermons, and in the long run will secure that co-operation on the part of the entire population without which the most elaborate legislation must needs remain inoperative.

## Notes on Current Topics.

### The Jenner Society.

THE report of this Society for 1899 and 1900, somewhat tardily published, affords a very good idea of the results of the last vaccination legislation. There has been an increase in the number of vaccinations equivalent to 33·8 per cent., and the ratio of successful vaccinations has also undergone a marked increase. This latter fact suggests a doubt as to the genuineness of many vaccinations performed by private practitioners under the old *regime*, indeed, it was a matter of public notoriety that, in deference to the whims of parents, some practitioners were in the habit of complying with the letter, rather than with the spirit, of the law. The improvement may be attributed in part to restored public confidence in the protective powers of vaccination as the result of the very thorough investigation at the hands of the Royal Commission, and partly also to the fact that vaccination has been brought to the doors of the great mass of indifferent people who, while they would not take any trouble to obtain the protection for their offspring, do not directly refuse compliance with the law. On bigoted anti-vaccinators the effect has been *nil*, except, perhaps, in that it has rendered them more obstinate and irreconcilable than ever. As the report says, when a man commits himself to a position which he can neither maintain intelligently nor abandon without virtually confessing that he has blundered, he is more likely to be exasperated than conciliated by being treated with magnanimity. The report deprecates the attitude of certain well-meaning magistrates who have placed difficulties in the way of the *soi disant* conscientious objector, and urges the maxim, *surtout pas trop de zèle*. Unquestionably this magisterial attitude has done something to maintain the feeling of hostility to vaccination, and is unattended by any compensating gain to the community. The imposition of heavy fines on obstinate recalcitrants is also disadvised as enabling them to pose as martyrs. The public vaccinator, it is pointed out, is still handicapped by competition with practitioners who content themselves with a single mark, and it is urged that there should be a statutory definition of what constitutes successful vaccination, otherwise vaccination is liable to be brought into discredit by reason of the inadequate protection afforded thereby. The only other alternative is that vaccination shall be done exclusively by men not engaged in private practice. We commend this report to the notice of our readers on account of the useful information which it contains on the working of the Acts and on the advantages of this method of protection against small-pox.

### Professor Koch and His Critics.

OPINIONS are divided, even in Germany, on the question of the identity of bovine with human tuberculosis. Virchow, on the one hand admits that the two are different, and even claims to have entertained this view all along, but he points out that

the non-identity of the two diseases does not necessarily entail the non-transmissibility of cattle tuberculosis to human beings, indeed he alleges clinical evidence to the contrary. He adds certain views which candidly do not assist in the understanding of the questions at issue. He warns us, for instance, against considering everything formed in connection with the tubercle bacillus as tubercle "since there are both bacillary and non-bacillary tubercle." Moreover, his opinion is that a small number of bacilli is not injurious, and he complains that this question of quantity has not been considered by bacteriologists. Professor Klebs, on the other hand, is very hostile to the view that human and bovine tuberculosis are essentially different, and he mentions a number of cases in which both adults and children have been infected by drinking the milk of tuberculous cows. He declines to admit that Koch's views are conclusive. In the mean time the German Government has appointed a committee, of which Professors Virchow and Bollinger are members, to investigate the points in question. It is officially laid down that there is at present no ground for modifying the precautions which are taken to prevent the spread of tuberculosis by milk and butter. It may be several years before the question of the difference of human and bovine tuberculosis is finally settled. Even on veterinary grounds dairy owners must still be required to sterilise their milk by means of heat, as otherwise there would be no means of preventing the spread of tuberculosis among their cattle. Consumers also are strongly urged to continue not to use milk before it has been thoroughly boiled.

### An "Eminent" Bone-setter.

A MEDICAL contemporary has drawn attention to the description of a garden *fete* recently published in the *Staffordshire Sentinel*. The Duchess of Sutherland, so it is stated, looked in at the park where the crippled children were being entertained, and was accompanied by an "eminent bone-setter," who has attended the Duchess and a number of her friends. As might have been expected this extraordinary proceeding has roused the local medical profession into arms. It is to be presumed that the crippled children were under the care of properly trained and qualified medical men. There is, perhaps, no single branch of surgery that demands more highly specialised and experienced skill than that of orthopædics. So fully is that fact recognised by most surgeons that they will not undertake the treatment of these deformities, but hand them over to their orthopædic brethren. Tenotomy, resection and grafting of bones, aseptic surgery, tendon grafting, and a host of mechanical appliances have greatly advanced the possibilities of this branch of surgical art. It seems incredible, under such circumstances, that educated people should be found ready to trust themselves and their friends to the tender mercies of a man untrained in anatomy and surgery. The responsibility of entrusting a number of cripples to an unqualified charlatan is simply

appalling, but, if we are to believe the *London Medical Sentinel*, the Duchess of Sutherland has not feared to undertake that risk. The extraordinary state of the law that permits the open practice of bone-setting by medically unqualified persons is so familiar that it hardly invites comment.

**Medical Portraits in Lay Journals.**

THE recent manifesto by the Council of the British Medical Association against the publication of the portraits of medical men in lay newspapers has received an early and somewhat amusing commentary. The portrait of the new President, Dr. Ferguson, appeared in the *London Sun* for the 7th instant, and by this time has doubtless illumined many other journalistic pages. If it be wrong for John Jones, a small practitioner in a provincial back street, to allow an enterprising editor to reproduce his classic features in the local press, surely it would be equally an ethical offence on the part of his professional brother who happens to live in a prominent position and to be the leading practitioner in the town. It really looks as if medical ethics failed to realise the fundamental principle of justice embodied in the homely proverb—“What is sauce for the goose is sauce for the gander.” The consultant condemns as an advertiser the general practitioner whose name is published in connection with this or that medical matter in the public press; but he winks at notices of his own class in connection with hospital affairs, new cures, and a score of things in which laymen are closely interested. He seems inclined to view the publication of portraits in much the same way. Not long ago a whole page, or thereabouts, was devoted in a South Wales newspaper to the portraits of the honorary medical staff of the Cardiff Infirmary. It would be interesting to ascertain how the Council of the Association propose to deal with wholesale offences of that nature.

**The Annual Dinner of the British Medical Association.**

A CORRESPONDENT writes:—The annual dinner of the British Medical Association, held this year at Cheltenham, will always be remembered as an occasion which was characterised by a series of “dumb crambo” shows on the part of those who were set down on the official programme as the speakers for the evening. It was useless for the Chairman, Dr. Ferguson, the President of the Association, to appeal to the audience for a few minutes’ quiet. The guests, to the number of over 400, had evidently come there to enjoy each other’s society and conversation; they did not actively object to the speakers, but they certainly were not going to listen to them, and so in a perfect babel of loud and cheerful talking and of roars of laughter, together with the noise of many waiters moving about, a long toast list was worked through. A curious fact was that the inability to be heard did not in any way affect the length of the speeches. In the case of one orator every artifice was employed to convey to the speaker the fact that time was short and others were to follow, for even the

bugler from the band was commandeered and loudly sounded the “Cease fire,” but all to no purpose—the eloquent but unheard oration was not shortened by one single sentence. With the exception of the trouble about the inability to hear the official speeches the dinner went off exceptionally well, and moreover many of those present were heard to declare that it was the most enjoyable public dinner they had attended for a long time.

**Medical Guardian and Medical Officer.**

SOME time since we alluded to the complaint brought by the Medical Officer of the Newton Abbott Workhouse against one of the guardians, also a medical man, on the ground that the latter in his official visits interfered with the treatment of the patients and criticised the diagnosis. A Committee of Inquiry was appointed, and they reported that the evidence was “not sufficient to find that any intentional interference had taken place.” One might have expected that the incident would end there, but with glorious inconsistency the guardians subsequently passed a vote of confidence in their medical officer, coupled with the hope that “he would have no further cause to complain.” It really looks as though either the medical guardian or the medical officer would do well to resign, and it is to be regretted that a purely personal matter of this kind should disturb the harmony of the Board. On the whole our sympathies are with the medical officer, who is perfectly justified in resenting even the appearance of interference with his professional functions by a fellow-practitioner.

**The Causation of Phosphorus Necrosis.**

ONE of the most useful addresses delivered at the Cheltenham meeting of the British Medical Association was that by Mr. W. F. Dearden, of Manchester, on “The Causation of Phosphorus Necrosis.” According to one school the fumes of the lower oxide of phosphorus given off from the moist phosphorus paste, in the course of manufacturing matches for use on the Continent, exercise an influence that is purely local. In the opinion of another body of thinkers the maxillary necrosis is a local manifestation of a general disturbance of the system. Mr. Dearden has very skilfully worked out his reasons for partially accepting both these views. He adopts, in fact, the commercial method of “splitting the difference.” It certainly seems clear that the possession of carious teeth is a necessary factor in exciting the acute local necrosis, but it is equally certain that phosphorus fumes exert no specific action on exposed bone or periosteum. There must be some systematic predisposing influence from a primary infection of the tissues acting as a necessary adjunct to the local excitation. This explanation places the local irritation as the actual exciting cause in quite a secondary position. This contention is borne out by the comparative frequency of the occurrence of spontaneous fractures of the long bones in match-makers of many years,

standing, and the brittle condition of the bone assuredly accounts in some degree for the low resisting power of the jaw to local inflammatory injury. Further, the bone of a match-maker and healthy bone show a distinct difference in the relative proportions of phosphoric acid to lime, and this also is observed in cases of "phossy jaw." By the aid of the X-rays it can be demonstrated that bone formed in young people working at phosphorus processes during the growing period is much denser in character than it would otherwise be. We quite agree with Mr. Dearden in his conclusion that certain changes do take place in bone tissue as a result of inhaling phosphorus fumes for long periods, and that it is reasonable to account for "phossy jaw" by local irritation through a carious tooth acting on bone already damaged as the result of a general infection.

#### How Cheltenham was Saved from Small-pox.

It is so usual to connect Government offices with red tape, delay, and muddle that when the Mayor of Cheltenham recently referred to the sensible manner in which the efforts of that city to control the well-known outbreak of small-pox at Gloucester were helped and encouraged by the Local Government Board his audience of medical men greeted the announcement with loud applause. In neighbouring Gloucester there were 430 deaths from small-pox recorded, and it was felt that immediate steps ought to be taken at Cheltenham, so the Mayor and Council snapped their fingers at precedent, and on their own authority made every medical man in the place a vaccination officer, and within a week or so the vaccination and re-vaccination of over 10,000 people was carried out. Twenty-three cases of small-pox were imported from Gloucester into Cheltenham; these were duly isolated, and the Mayor had reason to be proud in recalling the fact that they had not a single death in Cheltenham from the disease. The Local Government Board not only winked at the irregularity, but put matters straight by granting certificates to the medical men as Government vaccination officers.

#### Sanitary Bedding.

A CORRESPONDENT calls attention to the curious indifference of English people to the quality and cleanliness of their bedding, at any rate of certain parts thereof, notably the mattresses. He points out that in France even the working people are not content to lie on mattresses made up of the *débris* of old woollen rags, carpets, &c. Their bedding is of white wool and horsehair, and at least once in two years the mattress is picked to pieces and carded by itinerant women. There is undoubtedly much truth in the reproach, for the practice of having mattresses re-made seems to be almost unknown in England. This may be the effect or the cause of the process being so costly as not to be accessible to persons of moderate means. The consequence is, as many of us know to our cost, much discomfort and, not improbably, injury to health, for dust and dirt must accumulate in the interstices of the mattress

and undergo decomposition. The advantage of having the process of carding carried out under one's eye, so to speak, is that there is less risk of any portion of the contents being stolen or replaced by inferior material against which one can have no guarantee when it is sent to a factory.

#### Action for Slander.

A CURIOUS action for slander against a medical man was tried at the Birmingham Summer Assizes last week, when Mr. Gray, a dentist, claimed damages from Dr. E. W. Welchman, J.P., for having declined to give chloroform for a patient of his on the ground that he (the plaintiff) was not a qualified dentist. It appears that, as a matter of fact, the plaintiff is actually on the *Dentists' Register*. The defendant in his defence pleaded that he had received a circular warning him not to assist any unqualified dentist, and though the plaintiff's name was on the *Register* it was only in virtue of his having been in practice before 1878. The Judge put it to the jury that if the defendant had acted under apprehension of consequences in the event of the dentist being unregistered their verdict ought to be in his favour, and the jury thereupon returned a verdict for the defendant, to which the Judge added costs.

#### Unremunerative Honours.

ELECTION to the post of direct representative on the General Medical Council appears to be a somewhat onerous distinction, judging from Mr. George Brown's experience. In his speech at Cheltenham he plaintively referred to the fact that his annual fifty cases of midwifery had dwindled down last year to one, and that one a *gratis* case, in consequence of the demands on his time by attendance at the Council at Committee meetings. This is certainly a serious state of affairs, for the loss can hardly be compensated by the five guineas per afternoon dole which is all that the members get. As Mr. Brown put it colloquially, the post is "not a very fat thing." In spite of this disastrous effect on his practice, Mr. Brown asserts his willingness to continue his self-sacrificing efforts on behalf of his professional brethren. It remains to be seen at the next election whether his brethren will consider themselves justified in imposing the sacrifice upon him.

#### Diachylon.

THE frequent use of diachylon as an abortifacient in the city of Nottingham led to the Nottingham Medico-Chirurgical Society calling the attention of the British Medical Association to the matter. The matter was passed on to the Pharmaceutical Society with the request that steps should be taken to have diachylon scheduled as a poison. The Pharmaceutical Society appointed a special committee of the Council to consider the desirability of extending the schedule to the Pharmacy Act, 1868, and the correspondence from the Nottingham Medico-Chirurgical Society has been remitted to the special committee referred to. The members of the medical profession at Nottingham are to be complimented on the very

judicious course they have pursued in this somewhat difficult condition of affairs.

#### Reform in Soldiers' Dress.

THE dress of the soldier is one of the points that demands firm handling in the new era that it is not altogether unreasonable to hope will ere long descend upon the British War Office. At present the full dress uniform of many privates and of most officers is a survival of monumental foolishness, unfitted for either the arts of war or the purposes of peace. The garments are so heavy and tight fitting that they permit no departure from the constrained stiffness of the warrior standing at "attention," to say nothing of the fact that they are coloured so gaily, and loaded so heavily with metal buttons, and lace and other finery as to be a constant source of wearing anxiety to their owners. The first thing an officer does on returning from a full dress parade or other function is to revert to his loose patrol jacket. Indeed, it is rumoured that if Mr. Brodrick's proposal that officers in future should wear their uniform in public were carried out, at least half of the present army officers would forthwith resign. Why, then, should these uniform absurdities, which are so heartily disliked in the army itself, be retained to delight the hearts of servant-maids and drill-sergeants, not to mention army tailors? A good beginning has been made in the matter of supplying many regiments with slouch hats. In Italy the whole of a regiment while manœuvring near Naples recently, was attacked by malaria. The Minister of War has since issued orders that all troops in that district are in future to wear veils and gloves to protect them from mosquitoes. The good sense of that proceeding may well be commended to our army authorities at home. The relation of dress to disease is a most important point in military administration, and one worthy of the highest skilled investigation and control.

#### Underground Bakehouse Legislation.

THE question of underground bakehouses has again come prominently before the public by reason of certain amendments proposed in the Factory Acts, which will probably have been settled in the Commons one way or the other within a day or two. The main proposition brought forward is that all underground or cellar bakeries shall in future be abolished, except in cases where the local sanitary authority grant a special certificate of the fitness of the premises from a health point of view. In practice any condition of the kind is likely to reduce legislation to a dead letter. Experience has shown that many bakers are actually members of vestries or councils, and oppose any action against their fellow-tradesmen tooth and nail. There is also often a strong undercurrent of opposition on such boards against any interference with trade interests. The reasons why underground bakehouses should be abolished are numerous and weighty. They affect the health not only of the producers but also of the consumers of bread. The whole case has been investigated by

Drs. Waldo and Walsh, who have published a book, "Bread, Bakehouses, and Bacteria," which has for some years been the authority upon this subject, and has formed the basis of all recent bakehouse legislation. Their chief scientific point was the demonstration of the fact that the ordinary loaf is not sterilised by baking. If non-pathogenic microbes survive the ordeal of the oven it is fair to assume that pathogenic micro-organisms will also retain their vitality under similar circumstances. This non-sterilisation of the dough in baking proves the absolute necessity of a perfect sanitary environment in the bakehouse.

#### The Folly of Bolting Food.

A PAPER read before the British Medical Association furnishes some remarkable facts about the mastication of food. The author, an English practitioner in Venice, says that there exists a lost reflex action of the throat, whereby it refuses to swallow food unless well chewed and mixed with saliva. After five or six weeks of prolonged and careful chewing of solids and prolonged insalivation of fluids, this reflex can be restored. The necessary condition of success is that both fluids and solids shall be dealt with in the mouth until they are reduced to a tasteless condition. The author says that by adopting his process indigestion is vanquished, the body becomes healthy, a far smaller quantity of food is required, and in one case corpulency was reduced to an extraordinary extent. If his views be accepted the treatment of many maladies will be simply revolutionised. With the modern man quick eating has become a necessity, at any rate in the breakfast and luncheon hours. The tendency is to bolt everything at those meals, and to eat far too quickly even when there is ample time at disposal. It is clear that prolonged mastication would render a dinner of many dishes impossible. It is equally clear that most of us eat far more than is needful to satisfy our bodily requirements. That there is something to be said on the side of the quick eaters, however, may be gathered from the fact that many of them pass long lives without being overtaken by the Nemesis of dyspepsia. Among many native tribes, moreover, and with a host of carnivorous animals, it is the rule to bolt food in rapid and wholesale fashion.

#### The Public Endowment of Cancer Research.

THE shadows of the scientific world have long hinted at coming events in the curative and preventive aspects of cancer. It is now pretty generally believed that the dread disease in question is due to a parasitic organism which has gained access to the human body. If that be the case cancer is at once brought within the category of infectious and therefore preventible maladies. The importance of accurate knowledge upon these points to mankind generally can hardly be over-estimated. One is not surprised, therefore, to find an intelligent layman writing to the newspapers and advocating a plan whereby a number of endowments of £500 per annum

may be established for the benefit of medical men who will undertake special investigation of the disease. While fully endorsing the value of this suggestion we can hardly agree with his proposed plan of selecting the workers from physicians and surgeons with a large experience of the disease, and requiring them to work in the cancer wards of a general hospital. The purely clinical aspects of the disease have long been worked out, and the crucial problems of causation must be solved in the pathological and bacteriological laboratory. By all means let us have liberal endowments for cancer research, but let the money be spent in the right direction. Any philanthropist wishing to confer a lasting benefit upon the human species could hardly do better than found a special cancer laboratory. That would in many cases be a more logical and strictly philanthropic proceeding than the creation of pseudo-medical charities.

#### Indiarubber Corsets.

THE corset, as all the world knows, is an essential detail of the costume of the modern civilised woman. We use the term "modern" advisedly, because early woman was free from that artificial aid to symmetry which has appeared upon the scene only within the last hundred years or so. That it has some quality which commands the admiration of the fair sex is clear as daylight, otherwise it would have gone the way of crinoline and high waist and a hundred and one other absurdities of dress. The principle of the corset is that it supplies a "figure" built upon the unbending lines of beauty laid down by the dressmaking craft as the beau ideal of the feminine form divine. To that end this article of dress is made practically as a cuirass of stiff material strengthened and strutted with slips of steel, whalebone, and wood. The apparatus, in its present stage of evolution, has gained the wholesale contempt and detestation of all physiologists as an outrage upon the organs of respiration, circulation, and digestion. Lovely woman, however, contemptuous of mere scientific criticism, has carried her fashion a step nearer breaking-point by inventing corsets of indiarubber designed for bathing purposes. The idea of thus converting what should be a most wholesome and health-giving recreation into a field for exploiting various kinds of irrational dress could have been engendered only in the brain of a latter-day fashionable woman.

#### The Army Medical Service Committee.

SIR WILLIAM THOMSON, C.B., Fellow and late President of the Royal College of Surgeons in Ireland, has, we understand, been offered a seat on the Committee appointed to inquire into the present state of the Army Medical Department. Even if Sir William Thomson is able to accept the invitation, the representation of Irish Schools on the Committee will still be altogether too small, when it is taken into consideration that the number of medical officers in the B.A.M.C. who hold Irish qualifications

at present is equal to 37 per cent. of the entire number of officers. Sir Thornley Stoker, F.R.C.S., Ireland, has addressed a second letter to *The Times*, in which he calls attention to the fact that there is still insufficient representation.

#### Wage Limit.

THE question of the wage limit is generally believed to be a subject in which practitioners are keenly interested. It would, however, seem open to question whether, after all, the medical profession is really interested in this matter. In any event, it is noteworthy that although all the branches of the British Medical Association were written to, asking for the opinion of their members on the wage limit question only nine branches replied, and the others are now being stirred to activity by urgent appeals from the central authority to "give this important matter their careful and early attention." This fact certainly argues in favour of the opinion that this so-called burning question is in reality regarded with something akin to indifference by medical men in this country.

#### Cigarette Smoking.

Two hundred medical practitioners in Edinburgh and Leith have signed a memorial against cigarette smoking by children, and urging that steps should be taken by Parliament to restrict the sale of tobacco in any form to lads under sixteen years of age. There is no difference of opinion in the profession as to the deleterious effects of cigarette smoking by the young, but we are fain to admit that legislative prohibition will be very difficult to obtain and still more difficult to enforce.

#### A Warehouseman Vaccinator.

A GLASGOW warehouseman has recovered three guineas and expenses from the Glasgow Corporation for vaccination fees. It transpired that the plaintiff had been employed by the Corporation to vaccinate during the recent epidemic, and was promised six shillings a day, i.e., the same rate as that paid to medical students. The Glasgow corporation is known to be very enterprising, but this is an innovation of which it is difficult to approve.

AN action was tried last week at the Glamorgan Assizes in which a miner claimed damages from Dr. Ward, of Merthyr, for alleged negligent treatment. The plaintiff had sustained a fracture of the left forearm, and a false joint had resulted. Mr. Robert Jones, of Liverpool, was called on behalf of Dr. Ward, whose defence was looked after by the Medical Defence Union, and distinctly negated any suggestion of malpraxis, and a verdict was returned in favour of the defendant.

THE death is announced of Dr. Julius St. Thomas Clarke, of Leicester, which took place quite suddenly on the 2nd inst. Dr. Clarke, we may recall, was the victim of an assault by a lunatic last October, when he was shot with a pistol, the ball lodging in the lower part of the spine. There is no reason, how-



ever to think that his death had any direct connection with the injury.

PERSONAL.

MR. W. WATSON GRIFFIN, M.B., F.R.C.S., has been appointed Ophthalmic Surgeon to the Sussex County Hospital.

SUBRON-GENERAL T. F. O'DWYER, P.M.O., will shortly retire from the service on completion of his tenure of his appointment at Aldershot.

DR. C. W. DANIELS left Liverpool on the 8th inst., by the ss. "Sekondi," for Sierra Leone, West Africa, to join the sixth malarial expedition under Major Donald Ross.

THE resignations of Dr. Bassett Jones and Dr. Morgan, Honorary Surgeons of the Aberystwith Infirmary, have been accepted at a meeting of the management committee of the institution.

SIR FRANCIS R. CRUISE, M.D., Fellow and ex-President of the Royal College of Physicians of Ireland, has been appointed one of the honorary physicians to His Majesty the King in Ireland.

DR. FARQUHARSON, of Lichfield, has been appointed Medical Officer of Health to the Bishop Auckland Rural District Council, at a salary of £350 per annum. There were forty-two applicants, and the advertisement stipulated for whole services to be devoted to duties of the office.

A PORTRAIT of Dr. Thomas Young, copied from the painting by Sir Thomas Lawrence, has just been placed in the Victoria Hall, Milverton, Somerset, with an inscription in which he is described as "physician, natural philosopher, and master of many languages." Dr. Young died in 1775.

DR. HENRY C. WOODS, C.V.O., one of the King's Naval Honorary Physicians, who served in the Royal yacht "Victoria and Albert" from February, 1887, until his retirement a few months ago, has been appointed to a special post at the Admiralty, and has commenced his duties in Northumberland Avenue. Dr. Arthur R. Bankart, M.V.O., who attended the Khedive in the "Osborne" in July last year, has been appointed to Dr. Wood's vacant post in the Royal yacht.

Correspondence.

[We do not hold ourselves responsible for the opinions of our correspondents.]

BRITISH AND COLONIAL JOURNAL OF OBSTETRICS AND GYNÆCOLOGY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In your editorial note appended to the letters which appear in THE MEDICAL PRESS AND CIRCULAR of July 31st you state the opinion that "there is room for an 'imperial' journal of obstetrics and gynæcology." I can confidently assure you that it is an "imperial" journal which the promoters aim at, and they will be satisfied with nothing less.

There appears to be some misapprehension in certain quarters as to the origin of the present movement, and

the aims and motives which have influenced its promoters and supporters. It is difficult to see how any misunderstanding could arise. There never has been any attempt to conceal the incidents in the movement, and there can be no possible objection to a frank statement of what has occurred.

After conversations and consultations extending over many months among certain members of the North of England Obstetrical and Gynæcological Society, an informal provisional committee was formed at the beginning of this year with the object of ascertaining the views of the specialists of the United Kingdom and of the Empire at large on the feasibility of establishing a journal of obstetrics and gynæcology worthy of being ranked with those of Europe and America. This committee was selected according to definite principles in order to obviate any misunderstandings among the members of the Society, where so many were well fitted to undertake the work in hand. It consisted, when complete, of all the official teachers of midwifery and diseases of women in the four medical schools of the provinces covered by the Society. It was felt that we must first find out if the gynæcologists were strong enough to found a journal, and no appeal must be made in the first stage of the enterprise to the hospital surgeons who to some extent specialise, whether or not they were members of the various obstetrical or gynæcological societies.

I undertook the chief part of the correspondence, and was assisted by my junior colleagues, Drs. Arnold Lea, W. E. Fothergill, and Arthur Wallace.

We were all firmly convinced that the time had come for a successful enterprise of the kind, but we harboured no illusions. We knew it was a venture; we did not feel justified in formulating a scheme; we could not, therefore, influence opinion; we could only try to ascertain it and report. Most of our correspondents were as well acquainted with the position of British gynæcology as we were ourselves.

Out of the extensive correspondence which is now in my possession two facts soon became prominent: first, that the gynæcologists of provincial England, Scotland, and Ireland were practically unanimous and cordially favourable to the scheme, while the teachers of obstetrics and gynæcology of the Colonies and dependencies of the Empire were absolutely unanimous, and if possible more cordial still in their expressions of interest and promises of support—Canada, Australasia, India, without a Laodicean. Secondly, that the difficulties arising from apathy or hostility among certain circles of London gynæcologists were well nigh insuperable. To our surprise many of the friends and opponents of the scheme appeared in entirely unexpected quarters. There was not the clear line of cleavage which we anticipated from a more or less intimate acquaintance with the contemporary history of gynæcology in London.

To those of us in the north who know the motives and aspirations of the original promoters of the scheme it is startling to read that "it is an open secret the journal has been conceived and taken in hand mainly by those who are openly and avowedly hostile to the British Gynæcological Society and its *Journal*." No statement could more completely misrepresent the facts. It would be nearer the truth to say that the main obstacle in the way of smooth and rapid progress with the arrangements has been the hostility of the most influential members of the British Gynæcological Society residing in London. Yet there are many exceptions; verbally and by letter, both directly and indirectly, the provisional committee has received assurances of friendly interest, which will doubtless be changed to active support in due time.

The objections on the part of the leading men are natural and obvious enough; they are highly creditable to their loyalty, if not, with all respect, to their discrimination of the signs of the times and the requirements of contemporary British gynæcology. One of the most respected and influential members writes:—"I have spoken to several of our men and am confident that they will take no action without fully understanding how the Gynæcological Society is likely to be affected by the movement." And yet many of the

most active supporters of the new journal scheme are provincial or Colonial members of the British Gynaecological Society, and do not believe that they are acting in a way to prejudice its prospects. In my humble opinion the Society will be in the same position as other similar societies throughout the country which periodically print and distribute to the members the papers and contributions brought forward at the meetings, and its quarterly journal will not lose in the slightest its value, even if many of the contributors to its admirable abstracts and reviews of the contemporary literature of obstetrics and gynaecology could find energy and inclination to take part in similar work on the new journal. Why should such participation be considered incompatible with entire loyalty to the British Gynaecological Society? Let me also add that all the objectors and a good many apathetic correspondents appear to under-estimate entirely the character and position which the promoters intend the new journal to assume. Even with moderate success it must belong to a different category from anything at present published in this country. It will be necessary to look to Germany for something to compare with it in scope and quality. No question of rivalry can arise here. The only emulation should be in a patriotic endeavour to concentrate the intellectual activity of the Empire in a certain field of professional work so as to produce the highest possible result.

Our local provisional committee, after consideration of the correspondence, came without hesitation to the conclusion that we must proceed with the undertaking. The response surprised while it gratified the most sanguine among us. We deplored the sporadic apathy or hostility in London, but there could now be no question of the experiment being made.

The most natural proceeding appeared now to be the calling of a meeting of the friends of the scheme to take counsel as to the next steps. In arranging for such a meeting in co-operation with the most cordial and influential supporters of the scheme among the London colleagues, it was surely natural to invite the attendance of those who had from the first been unequivocally friendly to the enterprise? The promoters could at least count on friendly criticism and advice intended to be helpful. Whether the meeting would consider the moment opportune was another matter. In the name of practical common sense, what useful purpose could have been served by the introduction of a known hostile element even though small in amount numerically? Objections such as would emanate from a friendly source had been all well considered.

The circular calling the meeting was signed by twenty-four representatives of British gynaecology, and it was sent to between 180 and 140 medical men and women known chiefly as practising obstetrics and gynaecology in the United Kingdom. The list was compiled from reports supplied by the most prominent specialists in the various centres of population. The meeting was attended by representatives from every part of the country, and from the point of view of the promoters was most successful and satisfactory. A resolution was passed unanimously to the effect that it is desirable to establish a journal of midwifery and diseases of women for the British Empire, and that the time is opportune for the undertaking. A committee was then appointed to give effect to this resolution. That committee is now at work; it has reported to an adjourned meeting, and it will soon be able to announce the results of its deliberations.

In your note referred to you ask, "Who is responsible for the assumed privacy?" The privacy, Sir, is altogether assumption. It is a figment of your correspondent, and implies considerable creative power. "Privacy" of meetings twice summoned by seven score printed circulars, in association with unlimited correspondence and the most unconstrained conversation and gossip! There has been, of course, the usual conventional official reticence on the part of those chiefly responsible for the summoning of the meeting. It would have served no useful purpose to have laid themselves prematurely open to worry and misrepresentation from anonymous writers in the medical journals. What would the

objectors have done under the circumstances? If they had been conscious of the support of practically the whole British Empire, would they, knowing the unhappy differences among London gynaecologists, have begun the movement by proclaiming its initial stages from the hearthstone, or have called the meeting by advertisement? Or could they have postponed action towards the fulfilment of the wishes of the vast majority of their colleagues throughout the Empire until London factions were reconciled?

The committee which is making arrangements for bringing out the journal is, perhaps, just as representative as any that could be formed so as to include the same proportion of men who are practising purely as specialists in the United Kingdom. The names will appear in a circular which is in course of preparation and will be issued shortly. The list of collaborators who will be invited to co-operate with the editorial staff, and will include the names of the best known workers both at home and in the distant parts of the Empire, will also be published in due course, but its compilation is a work that requires time. In what they do the committee will be guided, I believe, only by the desire to make the future journal successful in every way. Whether the members reside in London or in any other part of the kingdom they are influenced as much by a patriotic desire to see one of the reproaches removed from British medical science, and as little by jealousy of individuals or of institutions, as are the men who write cordial letters in support of the journal scheme, with friendly wishes and helpful suggestions, from Montreal and Toronto, from Melbourne and Sydney, or from Calcutta and Madras.

It would be to me a cause for deep regret if by want of clearness in expression I should appear to say anything to hurt any susceptibilities. That is far from my intention. There is surely room for all patriotic men scientifically interested in their professional work to join in this enterprise? A British Empire journal will certainly be published, and it is my firm conviction that it will be established. It will be representative of British gynaecology in the fullest sense, and it will hold up its head in the presence of the best that Germany or France, or Italy or the United States of America can produce. Assuming the role of prophet like your correspondents, who prophesy failure, I can confidently predict that it will not be so very long before some of your correspondents, looking back on their efforts at opposition, will be congratulating themselves that they wrote anonymously.

I am, Sir, yours truly,  
W. J. SINCLAIR.

#### Birmingham Libel Case.

A SETTLEMENT was announced at the Birmingham Assizes, on the 6th inst., in the action brought by Dr. Alfred Hill, the Medical Officer of Health for Birmingham, against the *Birmingham Daily Gazette*. The ground of the action was that the *Gazette* had imputed to the plaintiff responsibility for shortcomings in the housing of the poorer classes. Defendants consented to judgment for £250 and costs, and withdrew the reflections complained of, but claimed to have acted *bona fide*.

#### Another Beer Poisoning Sensation.

A GREAT sensation (says the *Newcastle Journal*) has been caused in Trowbridge and district by the publication of the annual report of Dr. Thomas, County Medical Officer of Health for Wiltshire, in which it is stated that last December arsenic was found in beer from a certain brewery, and that in consequence a number of persons suffered from arsenical poisoning through drinking such beer. The attention of the brewer was called to the matter, and a sample of the glucose used was given to Dr. Thomas, which also was found to contain arsenic. The brewer immediately withdrew the contaminated beer from sale, and undertook to destroy the beer in stock. Samples of beer and glucose afterwards obtained and analysed were found to be free from arsenic.

#### The Dental Hospital of London.

HIS MAJESTY THE KING has been graciously pleased to grant his patronage to the Dental Hospital of London

which has recently been rebuilt in Leicester Square, London.

**Vital Statistics.**

THE deaths registered in the week ending August 3rd in 86 large towns of Great Britain and Ireland corresponded to an annual rate of 22.4 per 1,000 of their aggregate population, which is estimated at 11,463,026 persons in the middle of this year:—

Birkenhead 24, Birmingham 25, Blackburn 22, Bolton 24, Bradford 18, Brighton 17, Bristol 13, Burnley 25, Cardiff 11, Croydon 9, Derby 21, Dublin 20, Edinburgh 17, Glasgow 21, Gateshead 33, Halifax 11, Huddersfield 18, Hull 19, Leeds 29, Leicester 21, Liverpool 30, London 20, Manchester 29, Newcastle-on-Tyne 31, Norwich 15, Nottingham 23, Oldham 18, Plymouth 14, Portsmouth 29, Preston 27, Salford 25, Sheffield 23, Sunderland 27, Swansea 14, West Ham 31, Wolverhampton 11. The highest annual death-rates per 1,000 living, as measured by last week's mortality, were:—From measles, 2 in Edinburgh, 7 in Glasgow, 1.4 in Birmingham and in Sheffield, and 2.1 in West Ham and in Salford; from scarlet fever, 1 in Edinburgh, 1 in Glasgow, 1.2 in Blackburn, and 1.8 in Preston; and from diarrheal diseases, 27 in Dublin, 12 in Edinburgh, 73 in Glasgow, 5.1 in Newcastle-on-Tyne, 5.3 in Sunderland, 5.4 in Hull, 5.5 in Huddersfield, 5.9 in Leicester, 7.6 in Birmingham, 8 in Birkenhead, 8.6 in Burnley, 9.4 in Gateshead, 9.5 in Nottingham, 9.9 in Bolton, 10.1 in Leeds, 10.6 in Salford, 11.6 in Manchester, 11.8 in Portsmouth, 12.4 in Sheffield, 12.8 in Liverpool, 13.8 in Preston, and 14 in West Ham. In none of the large towns did the death-rate from whooping-cough, or from "fever" reach 1.0 per 1,000. The 69 deaths from diphtheria included 28 in London, 6 in Leeds, 5 in Sheffield, 5 in Leicester, 3 in Brighton, 3 in Cardiff, 3 in Manchester, and 3 in Salford. One death from small-pox was registered in London, but not one in any other part of the United Kingdom.

**Death under Ether at Leeds.**

AN inquest was held at Leeds a few days since on the body of H. Hodgson, æt. 12, of Piley Hill, Dodsworth, who died while undergoing an operation at the Leeds Infirmary, for a nasal obstruction. It was stated that the proper quantity of ether was administered, and after the operation had commenced the boy went into convulsions, which lasted about twenty minutes. Restoratives were applied, but in vain. The jury returned the usual verdict.

**The Sale of Drugs by Medical Graduates.**

THE Senate of the University of Aberdeen has issued the following pronouncement:—"Whilst it is admitted that the exigencies of practice in certain localities may sometimes render it unavoidable for a medical practitioner to supply to his patients the remedies which he prescribes, the Medical Faculty of this University is of opinion that it is undesirable and detrimental to the position of medical graduates of the University that this custom should be followed under other circumstances; and further, it regards the sale of objects other than remedies by its medical graduates as, under all circumstances, to be strongly deprecated."

**Dublin Death-rate.**

DURING the thirty-one weeks ending with Saturday last the death rate of Dublin averaged 27.9 a 1,000. The rate of mortality in London was 20; Edinburgh, 17.3; Paris, 18.4; New York, 19 per 1,000. Fifty-eight of the persons whose deaths were registered during the week were under five years of age (45 being infants under one year of age, of whom eight were under one month old). There were 23 deaths from diarrhoea, four from simple cholera, and four from whooping-cough.

**The Mortality of Foreign Cities.**

THE following are the latest official returns, and represent the last weekly death-rate per 1,000 of several of the populations:—Calcutta 114, Bombay 47, Madras 38, Paris 17, Brussels 14, Amsterdam 13, Rotterdam —, The Hague —, Copenhagen 21, Stockholm 15, Christiania 22, St. Petersburg 25, Moscow 36, Berlin —, Hamburg 20, Dresden —, Breslau 38, Munich 19, Vienna 17, Prague 23, Buda-Pesth 18, Trieste 23, Rome 17, Turin (10 days) —, Venice 23, Cairo 45, Alexandria 37, New York (including Brooklyn) 19, Philadelphia 26.

Royal Colleges of Physicians and Surgeons of Edinburgh, and Faculty of Physicians and Surgeons of Glasgow.

THE quarterly examinations of the above Board, held in Edinburgh, were concluded on July 27th with the following results:—

**First Examination.**—Of thirty candidates entered, the following fourteen passed the examination:—Leopold H. Gill, George A. S. Hamilton, James Murphy, Jessie Jean M. Morton, Henry G. Smith, James Watson, Ayodeji Oyejola, Edith Boomgardt, Ernest P. Titterton, George H. Waugh, Robert M. Fraser, Nicholas D. Sweetnam, William P. Walker, and Charles S. P. McDermott; and five passed in physics, four passed in elementary biology, and one in chemistry.

**Second Examination.**—Of twenty-seven candidates entered, the following fourteen passed the examination:—Joseph van Someren Taylor (with distinction) William H. Bealch, Broderick E. M. Newland (with distinction), Richard H. Rigby, Debendranath Banerji, Sybil Louie Lewis, John J. Lawton, Stephen McCarty, Bessie Chapple, Eileen FitzGerald, Claude E. Watts, Patrick Shaw, Robert D. Hirsch and William E. O'Hara; and two passed in anatomy and one in physiology.

**Second Examination.**—Of eight candidates, entered the following six passed the examination:—Andrew P. Walker, William F. Waugh, Urban Burston, Fergus D. Yourelle, John C. Grant and John Martin.

**Third Examination.**—Of twenty-six candidates entered, the following sixteen passed the examination:—Adam W. Hall, Thomas A. Mendes, Leo Levi, Charles S. Macaskie, John A. Douglas, William P. Cowper, Thomas J. Walsh, William J. Gray, John M. Gerety, George J. Harman, Annjuta Kellgren-Cyriax, Alice Esther Gilford, Peter O. Jollie, Shavaksha P. Mistri, Henry Carlaw, and John O'Connor, and one passed in anatomy and one in materia medica.

**Final Examination.**—Of eighty-four candidates entered, the following forty-eight passed the examination and were admitted L.R.C.P.E., L.R.C.S.E. and L.F.P., and S.G.:—David Mitchell, James C. Nicholson, Alfred A. Beeks, Claude St. Aubyn-Farrer, Jas. A. Baird, Frank J. Pattee, Raoul F. de Boissiere, Neil Gavin, Alice M. Marval, John B. Mason, Alice D. Sibree, Alexander W. Frew, Bernard Wood, Anthony Corley, Harry Holden, Norman L. Stevenson, Joseph Crawford, Frederic W. McCay, David G. Metheny, David L. Williams (with honours), Charles W. Sharp, Gopal Chunder Ghose, Michael B. Conroy, Alice E. Brown, Jeanie Newton, Walter G. Edwards, Herbert E. J. Batty, Cecil E. Martin, Augustus D'Souza, Jaysing P. Modi, Thomas F. Okell, Henry E. Blackwood, Patrick W. McHugh, Gerald S. Coghlan, Richard Fox, Behramji B. Paymaster, Jose S. da Piedade Rodrigues, Kaikhusroo D. Cooper, Ebenezer Millicans, Donald McNeill Ford, Walter Sykes, James H. Stewart, Hirie N. Anlesaria, Herbert D. Pitt, Darabshaw F. Sanjana, William P. Grellet, Helen M. Serjeant, and John Dunlop, and six passed in medicine and therapeutics, five in midwifery, and six in medical jurisprudence.

At the July sittings of the Scottish Conjoint Board held in Glasgow the following candidates passed the respective examinations:—

**First Examination.**—William Noble Walker, James Taylor (with distinction), James Alfred Ashurst, John Macnamara, Alfred Edwin M'Dougal, Robert Johnston Crawford, Charles Conway Fitzgerald, William John Cogan, W. N. Alexander, Daniel Thomas H. Crowley.

**Second Examination, Four Years' Course.**—Thomas Marshall Metcalfe.

**Second Examination, Five Years' Course.**—William Miller Ramsay, David Haig, James Booth Patterson, Thomas M'Master Glen, Alexander Glen, William Arthur Magill, James Macarthur, Patrick Thomas Doorly, Cecil James Todd.

**Third Examination.**—Angus M'Innes, Thomas Longmore Ashforth, Alexander Russell Young, Robert Calder Blyth, David Roberts Williams, Thomas Weir M'Cubbin, David Christie, E. Vithal Khedkar, Alfred Edward Griffith, Michael David Ahern, Grace Eleanor Soltau and Constance Muriel Scott, Samuel James Mathewson, Frederick Herbert Maberly, Arthur G. Jackson.

## Notices to Correspondents, Short Letters, &c.

**CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

**REPRINTS.**—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the publisher or printer before the type has been distributed. This should be done when returning corrected proofs.

**ORIGINAL ARTICLES** or **LETTERS** intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication but as evidence of identity.

**READING CASES.**—Cloth board cases, gilt lettered, containing twenty-six strings for holding the numbers of **THE MEDICAL PRESS** and **CIRCULAR**, may now be had at the office of this journal, price 2s. 6d. These cases will be found very useful to keep each weekly number intact, clean, and flat after it has passed through the post.

### THE CHELTENHAM WATERS.

A **DISTINGUISHED** visitor, on his arrival in the town at the opening of the Association meeting, was driving from the railway station on an omnibus, and he said to the driver, "What have you got here in this town?" to which the bus driver replied, "Mineral waters." The visitor further inquired what they were good for, and the reply was "For the doctors." It was a little difficult to make the driver understand that this last remark required explanation, but when he had at last grasped the visitor's need of enlightenment on what appeared to him such a simple matter the bus driver said, "Why, the doctors prescribe the waters to their patients and it gives them rheumatism and gout."

**TUBERCLE.**—The treatment is not one to be recommended in the absence of trustworthy data concerning the *modus operandi*. Judging from the information at our disposal it would appear not devoid of danger to the patient.

**V. M.**—Yes, in our Educational Number, which will appear early in September.

**CLEOPHAS.**—Your letter will appear in our next issue.

### WHY NOT SETTLE THE QUESTION AT ONCE?

At the last meeting of the Penge Urban District Council, Mr. Councillor West asked that the medical officer of health should be instructed to give a full report on the question of the inter-communicability or otherwise of bovine tuberculosis "so that the matter should be settled once and for all." It says something for the intelligence of the Board that the suggestion was received with loud laughter. In the meanwhile it was decided to affix notices forbidding spitting in the tramway cars, which is possibly a step of greater importance than that of reporting on the communicability of bovine tuberculosis.

"Well, madam," said the doctor, "how is our patient this morning?" His mind seems to be perfectly clear this morning, doctor," replied the tired watcher. "He refuses to touch any of the medicines"—*Chemist and Druggist*.

**CARDIAC.**—We are unable to accede to your request at the present stage, though your assistance may be appreciated later.

**S. V. R.**—You will find the matter has been dealt with in our issue for May 8th of this year.

## Appointments.

- BUTLER, WILLIAM, M.B.Glasg., C.M., D.P.H., R.C.P.S.Lond.,** Medical Superintendent, Isolation Hospital, Willesden, vice D. S. Skinner, M.D., resigned, and Assistant Medical Officer of Health to the Willesden Urban District Council.
- GOUGH J. H., F.R.C.S.Edin., L.R.C.P.Lond.,** Certifying Surgeon under the Factory Acts for the Torquay District of Devonshire.
- HASWELL, W. C., M.B., B.S.Durh.,** Certifying Surgeon under the Factory Acts for the Flaxton Rural District of the North Riding of York.
- MACNAIR, NORMAN, B.S., M.D.Glasg., M.R.C.S.Eng., L.R.C.P.Lond.,** Extra Dispensing Physician to the Glasgow Royal Infirmary.
- MURPHY, DENIS, L.R.C.S.Edin., L.R.C.P.Edin., L.P.P.Glasg.,** Pathologist to the Cork North Charitable Infirmary and County Hospital.
- PATRICK, E. M.D.Durh., M.R.C.S., L.R.C.P.Edin.,** Certifying Surgeon under the Factory Acts for the South-east Bolton District.
- PEARSON, H. CARDEN, M.B., F.R.C.S.Edin.,** Surgeon to the Darlington Hospital.
- TURNER, B. R., M.B., B.S.Camb.,** Certifying Surgeon under the Factory Acts for the Oundle District of Northants.

## Vacancies.

- Birmingham City Asylum.**—Senior Assistant Medical Officer, also Junior. Salaries respectively £180 and £130 per annum, with board, apartments, and washing.
- Brecon Infirmary.**—Resident House Surgeon, unmarried, Salary £100 per annum, with furnished apartments, board, and attendance.
- County Mayo Infirmary.**—House Surgeon and Compounder. Salary

- £100 per annum, with apartments, attendance, washing, fire, and light. Application at once to Dr. M. O'Malley Knott, Castlebar. (See Advt.)
- Denbighshire Infirmary, Denbigh.**—House Surgeon. Salary £100, with board, residence, and washing.
- Devon County Asylum, Exminster.**—Third Assistant Medical Officer. Salary commencing at £125 per annum, and increasing at the rate of £10 per annum to £135, with board, residence, &c.
- Devonshire Hospital, Burton, Derbyshire.**—Assistant House Surgeon. Salary £50 per annum, with furnished apartments, board, and washing.
- Eastern Counties' Asylum for Idiots, Imbeciles, and the Feeble Minded.**—Resident Medical Attendant, unmarried. Salary £100 per annum, with furnished apartments, board, and washing.
- East Riding of Yorkshire.**—County Medical Officer of Health. Salary at the rate of £400 per annum, rising by increases of £25 to £500 with allowances. Applications on or before September 28th to Clerk of the County Council, County Hall, Beverley. (See Advt.)
- Fulham Infirmary, St. Dunstan's Road, Hammersmith, W.**—Locum Tenent for four weeks. £3 3s. per week, with board, apartments, attendance, and washing.
- Kent and Canterbury Hospital.**—Assistant House Surgeon, unmarried. Salary £60 per annum with board and lodging.
- Lewes Dispensary and Infirmary and Victoria Hospital.**—Resident Medical Officer. Salary £100 per annum, with apartments, board, and attendance.
- North London Hospital for Consumption, Hampstead.**—Junior Resident Medical Officer for six months. Honorarium at rate of £60 per annum.
- Nottingham General Dispensary.**—Assistant Resident Surgeon, unmarried. Salary £180 per annum, increasing £10 every year, with furnished apartments, attendance, light, and fuel.
- Owens College, Manchester.**—Junior Demonstrator in Physiology. Salary £100 rising to £150 per annum.
- Plymouth Borough Asylum.**—Assistant Medical Officer, unmarried. Salary £150 per annum, rising to £200, with apartments, board, and washing.
- Royal South Hants and Southampton Hospital.**—Junior House Surgeon for six months. Salary at rate of £50 per annum, with rooms, board, and washing. Also Dispenser. Salary £60 per annum, with board, rooms and washing.
- Royal Surrey County Hospital, Guildford.**—Assistant House Surgeon.—Salary £75, with board residence, and laundry.
- Staffordshire County Asylum, Stafford.**—Junior Assistant Medical Officer, unmarried, Salary £150 per annum, with board, lodging, attendance, and washing.
- Stamford, Rutland, and General Infirmary.**—House Surgeon. Salary £100 per annum, with board, lodging, and washing.
- Toxteth Park Workhouse and Infirmary, Liverpool.**—Resident Medical Officer. Salary £100 per annum, with board, washing, and apartments.
- West Africa.**—Three Medical Officers to accompany Railway Survey Parties. Salaries £40 per month, plus allowances.
- West Ham Hospital, Stratford, E.**—Junior House Surgeon, Salary £75 per annum, with board, residence, &c.
- Wolverhampton and Staffordshire General Hospital.**—Assistant House Surgeon. Honorarium at the rate of £75 per annum will be given. Board, lodging, and washing provided. Also Assistant House Physician. Honorarium at the rate of £75 per annum will be given. Board, lodging, and washing provided.
- Wolverhampton Eye Infirmary.**—House Surgeon. Terms, £70 per annum, rooms, board, and washing.

## Births.

- GEDDES.**—On August 5th, at Winterton, Ferryhill, co. Durham, the wife of J. W. Geddes, M.B., C.M., of a daughter.
- PROBY-WILLIAMS.**—On August 5th, at 13, Welbeck Street, W., the wife of E. J. Proby-Williams, M.D., of a daughter.
- BUR.**—On August 1st, at 30, St. Mary's Road, Higher Crumpeall, Manchester, the wife of John Aust, M.R.C.S., L.R.C.P., of a son.
- SWALLOW.**—On August 2nd, at Taunton House, Clapham Road, S.W., the wife of Allan J. Swallow, M.B., B.S., of a daughter.
- WHITE.**—On July 28th, at Vanbrugh Park, Blackheath, the wife of Finch White, M.R.C.S., L.R.C.P.Lond., of a son.

## Marriages.

- CALVERLEY-DOVEY.**—On July 27th, at St. John's, S.E., Ernest Joseph Goodfellow Calverley, M.B., B.S.Lond., M.R.C.S., L.R.C.P., of Claremont House, Folkestone, to Evelyn, daughter of E. Douët, Esq., of St. John's.
- DARBYSHIRE-WORLEY.**—On August 1st, at St. John's Church, Perth, W.A., Douglas Edward Darbyshire, M.B., L.R.C.P., M.R.C.S., to Florence, second daughter of William Charles Worley, L.R.C.P., M.R.C.S., of Green Lanes, N.
- DONALD-BENNER.**—On August 6th, at St. Paul's, Winton-on-Tyne, David Donald, L.R.C.P., L.R.C.S.Edin., L.F.P. & S.Glasgow, to Bessie, daughter of the late Francis T. Benner, Newbiggin, Northumberland.
- HAY-MASON.**—On August 8th, at St. Andrew's Church, Deal, William Leslie Hay, M.R.C.S.Eng., L.R.C.P.Lond., to Mary, daughter of the late Thomas Edward Mason, M.D., and of Mrs. Mason, The Limes, Deal.
- LYLE SELFE.** On July 31st, at Holy Trinity Church, Blackheath Hill, Herbert Willoughby Lyle, M.D.Lond., M.R.C.S., F.Z.S., elder son of Thomas Lyle, M.A., to Elisabeth Ada, eldest daughter of James D. Selfe, of Blackheath Rise.

## Deaths.

- WILKINSON.**—On August 7th, at Bernard Castle, Durham, after a very short illness, Thomas Lewis Wilkinson, M.D., of the Grange, Exmouth, in his 78th year.

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## Original Communications.

### THE CAUSATION, PREVENTION, AND TREATMENT OF MISCARRIAGE. (a)

By PETER HORROCKS, M.D., F.R.C.P.,

President of the Obstetrical Society of London; Obstetric Physician to Guy's Hospital, London.

#### I.—CAUSATION.

THE term miscarriage is taken to include premature expulsion of the contents of a gravid uterus at any time from conception up to the end of the sixth month, before the fœtus is viable.

The term abortion is more commonly associated with criminal cases, and it is convenient to limit it to such cases. The proportion of miscarriages has been estimated at about 1 in 80 from hospital statistics, and at 1 in 5 from other statistics. In the statistical report at Guy's it was only 1 in 182. These estimates are of but little value, owing to the difficulties in obtaining accurate information. In all probability if all the instances could be collected, and particularly if it were possible to include very early miscarriages, the proportion would be even greater than 1 in 5.

Primiparæ are less likely to miscarry than multiparæ.

The possibility of pregnancy occurring at any time during an intermenstrual period with a miscarriage resulting at what would have been the first missed period is discussed, such miscarriages being spoken of as menstrual miscarriages.

The majority of known early miscarriages occur after one period has been missed, and such cases are mostly criminal.

The methods of criminal abortionists are mentioned.

Anything that disturbs the attachment between the fœtus and the mother may cause miscarriage. Hence increase of the intra-abdominal pressure from straining is one of the prolific causes.

These causes operate not only by separating the maternal and fetal parts of the placenta, and so causing uterine pains, but the blood may plough up the fetal parts of the placenta or the ovum, and so result in a carneous mole, and in later stages strains may actually rupture the membranes and so lead to miscarriage.

Shock and fright are causes, and the *modus operandi* is discussed.

In former days operations could often be done without disturbing the course of gestation. This is even more true at the present time, though occasionally miscarriage results.

Neighbouring diseases, such as fibroid tumours in

the pelvis, ovarian tumours, parametritis, perimetritis, Fallopian tube diseases, may cause miscarriage.

Tight lacing and great contraction of the pelvis, rectal diseases, and abdominal tumours interfere with the natural progress of gestation.

The rôle played by syphilis is discussed, and it is pointed out that as a rule the miscarriage is due to syphilis in the ovum, derived from the paternal element.

If a pregnant woman acquires syphilis after she has conceived, the child is not syphilitic.

Hydatidiform mole is described, and also fatty, calcareous, and inflammatory conditions of the placenta.

Excessive and scanty liquor amnii and malformations of the fœtus.

Deciduoma malignum is mentioned. Imperfect fertility due to extreme youth or age of one or both parents, or to debauchery or feebleness.

Affections of the umbilical cord, knots, shortness (disturbing the placenta), longness (round neck), &c. Diseases of the fœtus, causing its death, and so resulting in miscarriage. Endometritis, one of the commonest maternal causes of syphilis. Catarrhal endometritis with hydrorrhœa gravidarum described. The ill effects produced by criminal abortions and by methods adopted for preventing conception. The effect of sea voyages, sea sickness, &c., are discussed. Also, displacements of the uterus, blood diseases, convulsions, chorea, placenta prævia, cancer, over-suckling, deep fissures of the cervix, damage to the uterus, baths, alcohol, anæsthetics, habit.

#### II.—PREVENTION.

Avoid overstrain, shock, and fright. Operations not to be performed unless needful, especially extraction of teeth.

Avoid using instruments about uterus and cervix, and also avoid syringing. Pessaries should not be worn after the fourth month.

Purging should be avoided, and enemata, specially with turpentine or glycerine. Constipation should be avoided. Pelvic tumours may be pushed up into the abdomen or even removed. Endometritis must be cured. Cessation from coitus often permits of gestation progressing to term. Uterine displacements must be remedied. Avoid tight lacing.

Certain ecbolic drugs must not be given, such as ergot, savin, digitalis and quinine, lead.

Syphilis should be treated in both father and mother, and very often it is useful to give small quantities of mercury throughout pregnancy. General diseases must be treated with the appropriate remedies. Over suckling should be avoided.

Trachelorrhaphy sometimes enables the ovum to remain in the uterus.

(a) Abstract of paper read at meeting of British Medical Association, Cheltenham, August, 1901.

Alcohol should not be taken to excess, and in most cases should be avoided altogether.

High pyrexia from any cause should be brought down by cold baths, &c.

### III.—TREATMENT.

a. Avoidable. b. Unavoidable. c. Incomplete.

Rest in bed and some form of opiate the best treatment. If in doubt operate and clear out the uterus.

When there is serious hæmorrhage, or when os uteri is so large or expulsive pains so great and frequent that miscarriage is inevitable, allow it to take place, and, if need be, assist it either by puncturing the membrane or clearing out the uterus digitally under an anæsthetic.

When incomplete it is best to clear out the remainder. In some cases it is useful to pack the vagina with gauze. The bleeding is stopped or lessened, and uterine contractions are promoted, and later on it is much easier to deliver.

Vaginal injection of hot lotions are recommended by some, but they are not very trustworthy.

Dilators may have to be employed and ovum forceps and a curette, but it is better to mutilate the fœtus than to damage the mother.

Everything must be done aseptically, and if need be the uterine cavity must be swabbed out with tincture iodi or some other antiseptic.

## ASYLUMS AND ASYLUM WORK. (a)

By OSCAR WOODS, M.D. Dub.,

Resident Medical Superintendent, District Asylum, Cork.

AFTER cordially welcoming the members of the Medico-Psychological Society to the southern capital of Ireland, and thanking them for the high favour conferred on him by his election as President for the ensuing year, he said as this is the first meeting of the association in the Twentieth Century, I think that a short *resume* of what has been done for the insane, more especially in Ireland, during the century just closed would not be out of place, and afterwards I wish to point out what I hope will be effected early in the present one. The census report for 1851 stated that the first steps taken to provide for the lunatic poor in Ireland was in 1728, when the Lord Mayor of Dublin, Sir William Fownes, caused cells to be erected in the workhouse for the reception of lunatics. The Act 11 and 12 George III. (1772) was subsequently passed, enabling some provision to be made in workhouses for lunatics, but the first legislative enactment specially directed for the support of the insane appears to have been 27 George III., c. 39, which enabled grand jurors to present for the support of insane persons, and to provide wards for their reception in the county infirmaries. This Act was, however, little availed of. St. Patrick Hospital (Swift's) was founded in 1745, and at the opening of the 19th Century the only other provision existing for the care of the insane in Ireland was two institutions, known as Houses of Industry, one in Dublin, opened in 1772, the other in Cork, in 1787, the latter being the larger, giving accommodation for 425 patients, and admitting in the first twenty years of its existence 3,443 patients. The present Richmond Asylum, opened in 1815, grew out of the House of Industry in Dublin. In 1817 a committee was appointed to report on the state of the pauper lunatic in Ireland. It reported: "The common mode of treating the insane was when a strong young man is thus affected

the only way they have to manage him is by making a hole in the floor of the cabin, not high enough for the person to stand in, with a crib over him to prevent his getting out; the hole is about four feet deep. They give the wretched being his food in it, and then he generally dies." The friends did their best; the State had done nothing. The mode of treating the lunatics of this time was by confining them in wooden cells specially constructed for confinement and coercion. Hallam, writing about this time, says that most people believed in moon-madness, or, as described by the Irish, "Geal taigh cachet." Such then was the condition of the insane at the beginning of the last century. In 1817 nine asylums were ordered to be built, providing accommodation for 980 patients, at a cost of £204,000. In 1821 an Act was passed, enabling the Lord Lieutenant to direct any number of asylums to be built for such districts as should seem expedient, and when more than one county was included the asylum should be sufficient to contain not less than 100 or more than 150, but when only provided for one county a number of not less than 50. It was not till the 8 and 9 Victoria, c. 107, was passed that this legislation was repealed. The earlier asylums built were therefore all too small, and from that day to the present the Irish asylums have year after year been reported as overcrowded, notwithstanding that asylums have from time to time been built, and the older ones enlarged. At the present date there are 23 asylums, accommodating over 17,000 patients, and nearly all are overcrowded.

I extract the following information from the last report of the inspectors of lunatics; it is, however, arranged somewhat differently in order to show the number of lunatics and idiots at large in each census return. In 1851 the lunatics and idiots in asylums were 3,436; lunatics at large in workhouse and prison, 1,840; idiots ditto, 4,704; total not in asylums, 6,544. In 1901 the number of lunatics and idiots in asylums was 16,822; lunatics at large in workhouse and prison, 4,041. The number of idiots and lunatics at large, as returned in the last census is not yet available, but I have reason to believe it is not much, if at all, reduced. These figures show that there is still an ample margin for a large increase in the registrable insane without any increase in the occurring insanity. As a rule, all non-medical writers assert that lunacy is much on the increase, and one sapient statistician has calculated that in 400 years the sane people would be insufficient in numbers to put the insane safely under lock and key. However, the figures given above are such as to cause us to think seriously, and endeavour to suggest a remedy. If we deal with the registered insane alone, we find the following figures for the United Kingdom:—1859: Ireland, 6,734; England, 36,762; Scotland, 6,072. 1900: Ireland, 20,863; England, 106,611; Scotland, 15,663, or one registered insane person to the sane population in the following proportion:—1859—Ireland, 600; England, 535; Scotland, 505. 1900—Ireland, 213; England, 301; Scotland, 281. Thus, while in 1859 Ireland was the sanest portion of the United Kingdom, at the present time it has much the largest proportion of insane, having increased from 1 in 600 in 1859 to 1 in 213 of the same population in 1900. The population in 1859 was estimated at 5,861,711; by the last census return just issued it had been reduced to 4,456,546. This was largely accounted for by emigration to the United States, which country was glad to have our fittest and best, but took good care to return those who did not prove themselves mentally and physically sound, sending home those who showed the slightest symptoms of insanity, even after years of residence there.

It is very doubtful whether the latest attempt to

(a) Presidential Address delivered at the Sixtieth Annual Meeting of the Medico-Psychological Association of Great Britain and Ireland, held at Queen's College, Cork, July 25th and b, 1901.

deal with the chronic insane in this country will have good results. The Local Government Act of 1898, Section 76, made special provision for the care of the chronic and incorrectly-called harmless insane, but only provided a rate in aid of 2s. per head per week. This amount was, I am sure, fixed under a misconception, as the cost of 3s. 6d. per head mentioned in the Act, evidently referred only to cost for food incurred in many of the workhouses. A little agitation on the part of the Irish members could, I am sure, have this increased to 4s., and even if the local taxation account should fall short, which is possible, no Government could refuse to contribute the full quota to secure proper care for Irish lunatics. This provision of 2s. in the Act was evidently provided in order to better the condition of the unfortunate insane in the workhouses, who are admitted by all to be very inadequately provided for, but if the grant is not increased it will never be thought advisable to transfer patients from existing asylums where a rate in aid of 4s. per head per week is contributed to another institution where only 2s. would be received, even though it would be necessary to add inexpensive buildings to all the existing asylums. It is manifestly unjust to force on the County Councils the responsibility of providing for all the insane, and to lower the rate in aid per head from 4s. per week to 2s. for all in so-called auxiliary asylums.

It is unnecessary here to argue the important and much-vexed question as to whether primary insanity is on the increase or not; but as the number of registered insane is increasing and has to be provided for, every effort should be made to arrest if possible the progress of the disease. There is a marked difference in the type of insanity in Ireland and in Great Britain, for while a large number of the patients admitted into the asylums of this country are acutely maniacal, there is much less general paralysis and epilepsy. The prominent causes of general paralysis—syphilis, hard living, and intemperance—are much less potent in Ireland than elsewhere. Syphilis, which is so frequently the cause of general paralysis, is rare in this country, while in England and Scotland it is, at least in some districts, very common. Then the life led by the agricultural classes in Ireland is altogether different to the anxious, exacting, and toilsome life led by the lower classes in England and Scotland, especially in the cities and mining districts; and alcoholic stimulants, which, no doubt, contribute largely to this disease, are consumed in a very different way in the two countries. I can recollect no case of general paralysis ever coming under my notice in Ireland of an agricultural labourer who had not at some time been out of his own country. Soldiers, sailors, and occasionally members of the constabulary force are mainly the sufferers. Unless these reasons also account for the small proportion of epilepsy in Ireland I can give no explanation. The transmission of insanity by heredity is of importance, and we should aim at prevention in the near future by arresting heredity and encouraging in every way early treatment. Attention should also be devoted to providing hospitals for the treatment of the curable patients and villas for phthisical patients, and promoting pathological research.

1. The danger of transmitting insanity might be greatly lessened by more judicious marriages. I could give you case after case of the patients who have been more than once in an asylum entering into marriage shortly after discharge. Of course, such cases were almost bound to break down again, and to propagate children defective from birth, or who would develop insanity at some important epoch of life. In some districts in the south and west of

Ireland it is almost unknown for a man to select a wife outside his own circumscribed valley or neighbourhood, and this dislike to bring in new blood had very evil results. In some districts almost all the people have the same name, and another has to be added on to distinguish the families. I do not think it would be impossible to take steps, both medically and legislatively to arrest to some extent heredity. This was a matter of vital importance if they were to retain their present position among other nations, and of absolute necessity to the prosperity of the country. Typhus, fever, small pox, diphtheria, had been almost stamped out by sanitary precautions. Typhoid fever and other diseases are largely prevented by inoculation. Why, then, should not every possible step be taken to prevent the most pitiable, the most expensive, and to a nation the most degenerating of all diseases? It might be declared illegal to discharge any man or woman from an asylum during the procreative period of life unless perfectly recovered. Marriages of discharged patient ought not only to be discouraged, but under certain circumstances prevented by law, and practising physicians ought to be more alive to the danger of the neurotic, and those predisposed to insanity, contracting unsuitable marriages. Many would say they could not interfere with the liberty of the subject, and that restrictions of this kind were out of the question, but if this evil was not anticipated and dealt with more acutely than at present insanity must go on increasing.

2. The necessity for early treatment has not been sufficiently recognised either by the public or by law; nearly 50 per cent. of the insane are kept at home until they become a source of danger, thereby considerably lessening the prospect of their recovery, and acting as a means of propagating insanity and transmitting disease. I think it will be accepted that 45 per cent. of those admitted to asylums may be classed as incurable; many of them rendered so because they have not sooner been put under treatment, the friends looking on asylums as prisons, and believing patients cannot be sent in until they commit some indictable act, and except in very acute cases keeping them at home till they become dangerous to themselves and those about them.

3. A greater effort should be made to deal with premonitory symptoms, to watch those with hereditary predisposition at the critical periods of life, and establish hospitals throughout the country, where neurotic patients of all kinds could be treated. It should not be necessary to wait till certificates can be signed. Many asylums in England are now opening out-door departments; if this could be carried out I believe the loss of many valuable lives by suicide would be prevented, and the actual number coming under certificates would be lessened. Greater provision should also be made in all asylums for the separation and treatment of curable patients. I do not think any patients regarding whom there is a possibility of cure should be allowed into a ward with chronic patients, but should be separated in small wards, according to their mental condition, and placed in charge of fully-trained nurses in the proportion of at least one to five. A great step in advance has been made in the recently constructed English and Scottish asylums, but I hope before long every asylum admitting acute cases will have its detached hospital for curable patients, very much on the lines planned for East Sussex, and so lucidly explained to us last year by Dr. Hayes Newington. I presume it will be admitted that in the majority of asylums not more than 5 per cent. of the population are curable, and for them money ought to be spent ungrudgingly. It is difficult to treat properly acute mental cases, many of them of the most nervous temperament, in the wards of a chronic asylum, but

less expensive buildings than most of the English modern asylums would, I think, suffice for the care of many of our demented patients.

4. When we find that the death-rate from phthisis varies from 17 to 40 per cent. in asylums, it is surely necessary that more active steps were taken to arrest a disease which is now generally recognised, with proper precautions, to be preventible; no doubt the insane are specially prone to it, and it is very difficult of detection without the careful observation of both physicians and nurses, but with early recognition, complete isolation in suitable villas with a maximum of sunlight and open air, and a thorough disinfection and destruction of all bacilli, much might be done to stamp out a disease infectious and, in a well-organised institution, largely preventible.

5. Pathological work will, I trust, take its proper place in asylums, and the good example shown by the London County Council and Scotland be followed in other districts. At present an effort is being made to legalise the appointment of a pathologist for the Irish Asylums, and will, I hope, bear fruit at an early date. The Chief Secretary, in reply to a deputation that waited on him recently, acknowledged the necessity; with his sympathy and aid I hope the difficulty will soon be got over, and that the various asylum committees will quickly co-operate and appoint men of the fullest experience to carry out a work of vast benefit, not only to the present, but to future generations, and to the nation at large.

But these recommendations mean money, much can be done in England and Scotland that cannot be attempted in Ireland, and it may not be out of place here to quote a sentence from the report of Dr. Curwin, Superintendent of the Warren Asylum, U.S.A., who not long ago visited this country, and, referring to Irish Asylums, wrote: "It is earnestly and sincerely to be hoped that the English Government which has the control and direction of all matters concerning the expenditure for such institution in Ireland will awaken to the urgent necessities of the situation, and extend a helping hand and a generous support to the most dependent of its people by the provision for more extended means for their relief and maintenance."

Although the English Government has not the control and direction of matters concerning the expenditure, I fear much must remain undone till more liberal aid is given by the Government for the insane poor. Lunatics have a special claim on the State. Why should not the example which has been set with such good results by the American Government be followed, and asylums be supported altogether out of State funds?

This change was inaugurated in the United States on October 1st, 1893. What are the results, and what was almost the first recommendation of the Commission? "That all State hospitals which are not already provided with suitable facilities for specialised individual treatment of recoverable cases, provision be made for the erection and equipment of small hospitals, sufficient to accommodate about twenty-five patients, with their attendant nurses, one building for either sex, and that these buildings be supplied with everything in the way of structural arrangements, and medical appliances and equipment, that may be regarded as necessary to ensure to their inmates the highest degree of medical skill and treatment." The State Commission also made provision for the pathological research of the most complete kind recognising that the pathology of insanity is not definitely established, and of the great advantage that medical science, and through it the general public, would derive from a correct knowledge of this subject, which might be applied not only to the cure, but also to the prevention of mental disease, the Commission feels that the importance of this recom-

mendation can scarcely be overstated. Now what is the result of this important change? Dr. Wise, President of the State Commission in Lunacy, giving his experience of five years' working, states that the State Care Act "will ever stand as a monument of the progressive spirit of our commonwealth." He quotes one superintendent who was opposed to the change, but who now writes, "In all that pertains to the care and treatment of the insane, whether it be in structural provision, equipment, a high standard of repair, nursing and personal attendance of patients, the medical service and scientific inquiry and observation, the personal liberty and diversion of patients, and all that tends towards their cure, contentment, and comfort, the quality, the preparation of food; to the physiological curative needs of the insane, the clothing of the patients, and in all other things this hospital has progressively and steadily advanced its standard under the present system, and I truly believe this applies to all the other hospitals in the department of insanity."

Testimony such as this is abundant, and while there is a unanimity of opinion that the standard of improvement has been raised by 50 per cent., it has been effected at a reduction of the cost of more than 20 per cent. Dr. Wise is so enamoured of the good done that he concludes his pamphlet in the following words: "Like planting and cultivating will produce an equally rich harvest in all institutional work for charity, reform, and correction." This is indeed remarkable, and very strong testimony, and ought not lightly to be set aside; we live to learn, and in a poor country such as this, State aid cannot be too liberally dealt out to the most afflicted of all God's creatures. Whatever legislation decides as to the future of the insane, we must not forget that we have committed to our charge those unable to assist themselves. We are in all cases their guardians and guides, let us then endeavour to do our duty so that it may be said of us as Shakespeare said of the faithful servant:—

"O good old man, how well in thee appears  
The constant service of the antique world,  
When service sweat for duty not for meed.  
Thou art not for the fashion of the times  
When none will sweat but for promotion."

## THE USE OF DRUGS IN PULMONARY TUBERCULOSIS. (a)

By W. R. HUGGARD, M.A., M.D., F.R.C.P.,  
Davos Platz, Switzerland.

IN regard to the use of drugs in pulmonary tuberculosis there is much difference of opinion among medical men. By some physicians drugs are considered either useless or harmful; by others one drug or method of treatment is considered *the* treatment. Creosote, cinnamate of soda, arsenic, formaldehyd, and various other drugs have each their devoted adherents, who regard their pet remedy almost as a specific. A large number of medical men, while not discarding drugs altogether, employ them only for the relief of urgent symptoms.

All these views are, in my opinion, too narrow; some over-estimating the power of drugs, and others over-estimating their limitations. From another standpoint, also, the foregoing views are too narrow. The great variety in the clinical forms of phthisis is dropped out of sight; and the same line of treatment in regard to remedies is sometimes adopted without sufficiently precise reference to the case in hand.

(a) Paper read before British Congress on Tuberculosis, July, 1901.



The object of this paper is to point out some of the advantages that may be gained by the judicious use, and some of the evils that arise from the injudicious or indiscriminate employment of drugs in pulmonary tuberculosis. The broad principles will also be indicated which determine my own selection of remedies according to the variety of the case. The subject is one in which the comparison of individual experience is of the greatest value in extending our knowledge, and in putting it on a firmer basis.

The first point to be made clear is that up to the present no specific has been found for tuberculosis. Not merely so; but there is no drug that is useful in all cases. Nevertheless there are various drugs that favourably influence the course of some varieties of the disease always provided that they are well tolerated by the patient, and that they do not cause any disturbance of appetite, digestion, or assimilation. Time does not permit even a hasty review of all the drugs useful in phthisis. The various conditions only that indicate or contraindicate one remedy rather than another will be rapidly considered.

What medicines have we at our disposal? Drugs may favourably influence the course of the disease—

1. By improving the general health; as, for example, arsenic, quinine, strychnine, lime, phosphorus preparations.
2. By increasing the local resistance of the affected tissues, as creosote and its derivatives, salicyl preparations, and counter irritants.
3. By modifying the quantity or character of the secretions, as the balsams, the terebinthines, the essential oils, morphine and apomorphine, and inhalations, especially of formaldehyd.
4. By controlling systems that react prejudicially on the patient. Among these are—

(a) Digestive ailments. (b) Excessive or needless cough, which shakes and exhausts the patient, causes fever, or prevents sleep. (c) Scanty expectoration and retention of secretions. (d) Fever, which spoils appetite, and prostrates the patient. 5. By removing complications, such as syphilis.

In the choice of remedies the points to be considered are not the same as guide us in diagnosis or in prognosis. The first and most important point to recognise is, that treatment by medicines must be altogether subordinate to general hygienic management—good food and fresh air with rest and exercise, according to the individual needs of the patient.

The first and most important point in treatment is to consider the state of the digestive system. If the stomach or digestion is out of order drug treatment is, as a rule, inadvisable, except in so far as it may aid in restoring the digestive functions to a normal state, or in removing some condition that tends to prolong the digestive ailment. For example, appetite and digestion not uncommonly improve with the artificial reduction of temperature, or with the control of excessive cough. In such cases we must feel our way cautiously and be guided tentatively by the results. The most important indication then is to get the stomach and bowels into proper working order. Nothing goes right so long as the digestion is wrong.

Temperature is the next most important guide to treatment. Pyrexia will in a large proportion of cases yield to absolute rest, bodily and mental, combined with life in the fresh air. In many cases, however, a return to a normal level of temperature can be hastened by the administration of small doses of phenacetin—one to three grains—in combination with quinine and salol and sometimes arsenic. Taken in this way phenacetin seems to have rather a tonic than a prejudicial effect on the heart and on the general health, and may without hesitation be continued for months if need be. My experience of other antipyretics, save for occasional use, has not been so favourable, with the exception perhaps of salipyrin.

Arsenic, quinine, and salicyl preparations greatly diminish, in my opinion, the tendency to recurrent attacks of subacute inflammatory character and those recurrent febrile attacks without any change in the physical signs which are so marked a feature in a large number of patients suffering from pulmonary tuberculosis. These recurrent febrile attacks are no doubt of very various origin, tubercle as a rule rendering the organism highly sensitive to influences that cause pyrexia. The drugs I have mentioned seem to me to diminish this sensitiveness to febrile reaction. In doing so they accomplish something more than the avoidance of a temporary drawback or inconvenience. In tuberculosis, more than in any other disease, slight drawbacks are apt to provoke further prejudicial effects, and each morbid condition tends to become chronic. In averting slight drawbacks, therefore, we avoid great dangers which might completely alter the course of the disease. The disease is one in which pre-eminently anything short of the best is bad.

Next to pyrexia, as a guide to treatment, I would place a marked tendency to hæmoptysis. Creosote and guaiacol increase, in my opinion, the liability to pulmonary hæmorrhage—as well, in fact, as to pulmonary inflammation—and should be avoided where such a disposition is present. The lime salts, the terebinthines, and the balsams have, I believe, on the contrary a somewhat restraining influence, as has also morphine in minute doses.

The treatment of excessive cough requires much judgment. A closely allied object of treatment is the modification and, as a rule, the diminution of bronchial and pulmonary secretion—the “drying up of the lungs.” A certain amount of cough is in a large number of cases indispensable, and has a salutary influence. The problem is to secure the removal of the pulmonary and bronchial secretions with the least amount of virulence, exertion, or fatigue for the patient. Sometimes the secretions are extremely abundant, sometimes too scanty. The balsams and the terebinthines and tar for the most part diminish bronchial secretion, and the terebinthines commonly render it at the same time less tenacious and easier to get up. Minute doses of morphine—from one hundred and twentieth to one sixtieth of a grain of any of its salts—diminish secretion, but as a rule render it more tenacious. Apomorphine in small doses—one-twentieth to one-sixteenth of a grain of the hydrochlorate—loosens the secretion without making it much more abundant. The recently introduced morphine derivatives, heroin and dionin, greatly diminish cough, and to some slight extent diminish expectoration, while they are free from the drawbacks that morphine has, of rendering the secretion viscous and difficult to get up. They are also practically devoid of constipating effect, and they do not upset the digestion. For the last two or three years they have almost altogether replaced in my practice the phosphate of codeine, which has fewer drawbacks than has morphine for the relief of excessive cough.

The most valuable agent that I am as yet acquainted with for modifying the bronchial and pulmonary secretions is the vapour of formaldehyd. For the last three years I have used this drug extensively, and with more and more satisfactory results. When steadily used it generally causes the secretions to be less purulent and more mucous, at the same time diminishing the amount and rendering expectoration easier. Where the use of the drug has been steadily persisted in for months, tubercle bacilli have, as a rule, also become less numerous, and in some old cases even have disappeared. The mode of employment requires a little care. The best way, in my opinion, to use formaldehyd is by means of a muzzle inhaler. The strength of the solution should at first

not be more than two or three per cent. in rectified spirits of the ordinary forty per cent. solution. The addition of some essential oils renders the inhalation quite agreeable. Only from five to ten minims at first should be put on the inhaler, and this quantity should be renewed every fifteen or twenty minutes, the entire time of inhalation being from two to four hours a day. The strength may be gradually increased up to 6 or 8 per cent., and sometimes even to double that amount. If cough is very irritable, chloroform may be added to the inhalation. From independent observations I am strongly of opinion that chloroform, apart from its soothing influence on the cough, has in some cases a beneficial influence on the disease. It must, however, be used with judgment. I have known it seemingly give rise to pyrexia, by causing retention of secretion. The inhalation of formaldehyd on the contrary tends considerably to diminish pyrexia due to the absorption of toxins. Formaldehyd has another advantage. If not too strong, it diminishes irritability in the pharynx and larynx. It is, however, very irritating to the eyes and nose, and for this reason should be used only with an oral inhaler, or if the Burney Yeo oro-nasal inhaler is employed, it should be placed below the nose.

According to my experience syphilis is a complication of pulmonary tuberculosis in a much larger proportion of cases than is usually thought. In such cases I consider the treatment of the syphilis to be of the first importance. Small doses of the perchloride of mercury have then, instead of a depressing, a remarkably tonic influence. Intra-muscular injections of mercurial salts, though more strikingly beneficial, have as a rule the drawback of being excessively painful. To this rule, however, *huile grise* or mercurial ointment, rubbed up with sterilised oil, is an exception. The iodide of ethyl inhalation is perhaps the least objectionable, while not the least efficacious mode of giving iodine. It may be combined with the formaldehyd inhalation.

To sum up, then, my line of treatment is determined, in the first instance, by the digestive system, by the general health, and by the state of nutrition.

If digestion is bad the only drugs indicated are such as will restore it to a normal condition. If digestion is good, the general condition satisfactory, and the patient improving, I refrain from using drugs unless some definite indication is present. Among the most important indications for drugs are persistent afternoon pyrexia in spite of absolute rest out of doors; a tendency to recurrent febrile attacks or to slight inflammatory attacks. This tendency is usually combined with impaired nutrition and with a low state of general health. In these conditions arsenic, strychnine, quinine, and salol are among the most useful tonics. Active softening, excessive cough, overabundant expectoration, and, more rarely, scanty expectoration, expectoration of extremely purulent or nummular character, require attention; and the drugs useful for these conditions generally seem to me to have a favourable influence on the course of the disease in addition to the temporary relief from discomfort they may afford. Among such drugs are formaldehyd vapour, creosote and its derivatives, except the carbonate of guaiacol, which has generally seemed to me to be inert, terpin hydrate, oil of cinnamon, myrtol, the balsams, and the lime salts. In sluggish chronic softening, counter-irritation by iodine or by small flying blisters is of the greatest use. When an old syphilitic taint is present its removal should be our first care.

The short time at my disposal does not permit a detailed examination of the points I have brought forward, and my remarks are rather to be considered in the light of heads for discussion than as

even a partial exposition of the subject. What I have said may, however, I trust, be sufficient to induce others to bring forward their experience on the same lines.

## INOCULATION AS A PREVENTIVE AGAINST TYPHOID FEVER. (a)

By HENRY M. CULLINAN, L.R.C.P., L.R.C.S.I.,  
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In venturing to write on the subject of preventive inoculation against typhoid fever—a measure of treatment which, so far, is on its trial, and which can hardly be said to have been yet adopted by the medical profession—I should like to preface my remarks by stating that, in presenting the result of my experiences gained in the inoculation of over five hundred female patients in the Richmond Asylum during the recent epidemic of enteric fever, I lay no claim to have made a discovery, and it is possible that, had my opportunities for testing the efficacy of this treatment fallen into other hands, more interesting results might have been forthcoming. At the same time I have considered that the conclusions to be drawn from the occurrence of this epidemic in the Richmond are interesting, and justify me in placing before you the result of my observations, principally in the hope that any discussion which my remarks may give rise to will be of practical utility, and draw from those present suggestions which may guide us in the preventive treatment of this disease.

The epidemic referred to occurred in the Asylum last year, extending over some five months, and was of considerable severity. There had been cases of enteric with long intervals between each for about a year, but in August last the number of cases began to assume the proportions of an epidemic. When eighteen cases had occurred within three weeks it became evident that a serious state of affairs existed, and Dr. Conolly Norman, Medical Superintendent, obtained from Professor Wright, of Netley, a supply of lymph, which he has introduced for inoculation or vaccination against enteric fever. On receipt of this I commenced operations, and inoculated in rapid succession 307 female patients, inoculating each patient once only with  $\frac{3}{4}$  c.c. of the serum, commencing on September 6th and finishing on October 3rd. I had then operated on all the patients who lived and slept in the portions of the Asylum which were considered infected areas. It was suggested to me by some enthusiastic medical friends that I should vaccinate only one-half of the patients in each ward, in order to see if the other half would contract the disease, but I did not feel justified in adopting this course, however interesting the result might have been; on the contrary, the cases were becoming so numerous that our only anxiety was to inoculate everybody as rapidly as possible. However, unintentionally, I did, in fact, experiment, inasmuch as we did not inoculate any of the nurses, and it will be observed that in proportion to their numbers our staff suffered much more severely than the patients; also, having completed the inoculation of these patients, comprised in certain wards, and numbering, as stated, 307, the operations were stopped, and it was not until November 5th, when it was found that the wards which had not been gone over, and which had been looked on as immune, began to contribute cases, and severe cases, to the number attacked, that I again

(a) Read before the Section of State Medicine of the Royal Academy of Medicine, Ireland, April 28th, 1901.

started and inoculated the remaining patients in the house, by which I mean all those of 55 years and under that age.

The most interesting and important point in these experiments is, of course, to determine whether the vaccination confers any immunity against typhoid fever. I have come to the conclusion that it is of the utmost value in this respect, and I hope I am not incorrect in forming that opinion, deduced as it is from the records kept of the dates in which cases occurred and the very important and practical fact that out of a total of 511 patients inoculated only seven contracted the disease, and almost all of these were, in my opinion, in the incubation stage when inoculated. As already mentioned, eighteen cases had occurred when the vaccination was commenced on September 6th. Of these, ten were patients and eight were nurses. Owing to want of hospital accommodation we were able to operate on only forty patients at a time, and as these were kept three or four days in bed it took some time to go over them all.

While the inoculation was in progress—that is, from September 6th to October 3rd—nine fresh cases occurred, of which only three had been operated upon. Of these three there is no doubt that one was actually in the early stages of the disease at the time of inoculation, as, owing to an oversight, her temperature was not previously taken, but was found to be 101° immediately after the operation, remaining high and at once assuming the characteristic curve of enteric fever. Case No. 2 was found to have normal temperature, and was apparently in good health before inoculation. The temperature rose after the operation, but instead of coming down in a few days, persistently remained high and assumed enteric features almost at once, and, as immunity is said not to be conferred until from three to five days have elapsed after inoculation, I think it may be concluded that she would have contracted the disease in any case. The third case was inoculated on September 22nd, and on the 24th was quite well apparently, but on the 28th was found to have a temperature of 100°, and a couple of doubtful rose spots. On the 30th there was a typical crop of spots, and the case from that out was a severe one, complicated later on by double pneumonia, from which, however, she recovered, and has since left the Asylum.

I would not place this case definitely among those suffering from prodromal signs at the time of inoculation, but allowing three or four days to the serum to confer immunity, and as the spots began to appear six days after the operation, I think we may fairly refrain from blaming the lymph. A girl who had been inoculated on October 3rd, having left hospital three days after vaccination, was attacked very severely on October 15th. She was found on this date to have a crop of spots. This patient, I regret to say, died. It must be remembered that in an asylum patients are frequently walking about with a high temperature and severe symptoms unknown to the medical staff and without complaint; and it is only when they get very ill that they are noticed to be so. Accordingly, it is difficult to determine when this patient began to be the subject of enteric fever.

On November 5th, owing to several cases having occurred among patients not inoculated, I resumed operations, and vaccinated 204 females, making a total of 511. I am much indebted to my recent colleague, Dr. William Starkey, for his assistance in inoculating a considerable number of these patients.

On November 14th a patient who had been inoculated on September 22nd—nearly eight weeks previously—and had been quite well in the interval, was found to have a most profuse crop of spots. This is an example of a case in which the serum failed to do its work, and it also exemplifies the fact that lunatics

will often walk about with a severe disease attacking them, seemingly in normal bodily health, as this woman only complained of feeling ill when she actually exhibited the spots in great numbers. Another patient, inoculated on November 12th, was very ill after the operation, and continued so with a high temperature. On the 20th she had a crop of spots, having had all the appearance of typhoid in the interval. This may, I think, be considered a case in which the patient was sickening for the disease at the time of inoculation.

Another woman, about fifty years of age, operated upon on November 5th, and getting over the effects in three days, was found on November 17th with a temperature of 101°, and had a very severe attack, followed by a relapse, from which she nearly died. I consider that on this occasion the serum acted detrimentally, and probably accentuated the severity of the attack.

In order to prove the efficacy of serum inoculation as a preventive measure it is necessary to show that those treated were living at the time within an infected area. This was undoubtedly the case in the Richmond, as, although the place was thoroughly overhauled by the Public Health Authorities, and a new system of drainage laid down with great promptitude, cases continued to occur with persistent regularity, mostly among the staff—a total of seventeen nurses being attacked, of which nine contracted the disease after the inoculation of patients commenced, none of the nurses having been operated on. Twenty-eight inmates were attacked during the inoculation process, of whom only seven had been operated upon—showing that during this period thirty-seven cases had occurred, proving conclusively that the source of infection still existed. The last case which occurred was a girl admitted about five weeks when she was attacked, a fact which adds weight to this statement.

The question might be asked, Would these patients who were inoculated and escaped the disease have contracted it had they not been inoculated? This, of course, I am not in a position to answer, and it would, I think, be quite impossible to ascertain. The fact remains that they *were* inoculated and *did* escape.

With respect to the constitutional disturbance following inoculation it did not prove in any of the cases in my experience to be of great severity. In every case, almost, the temperature rose within a couple of hours, in some few instances reaching 103° and 104° the day of operation, while 101° and 102° were common heights for it to attain. It usually fluctuated for a couple of days, coming down gradually from the maximum, and being generally normal on the third day. In every case operated on four-hour temperature records were kept. Except in the cases already specially mentioned the patients were able to be up and about on the fourth day. The principal symptom was headache, from which eighty-five suffered, some of them very severely. Vomiting or retching occurred in sixty-three cases, loss of appetite and refusal of food in thirty-three, diarrhoea in two, rather severe prostration in three; four complained of abdominal pain, while stiffness in the back and soreness over the seat of inoculation occurred in nine and twenty-two cases respectively. The last symptom—soreness in the flank, where each patient was vaccinated—was not in any case accompanied by local manifestation beyond slight redness of the part, with some swelling.

I should have liked to have been able to compile a table in which the agglutinative action of the blood serum of each patient on the bacilli before and after inoculation was shown, but unfortunately the rapidity with which cases occurred created something of the nature of a panic, added to which, coming on during

the vacation season, we were handicapped as regards medical assistance, for which reasons the inoculations were performed as quickly as possible without first examining the blood, except in a certain number of cases, not very large. On examining the reaction of the serum in these cases, I found that in every instance there was a certain amount of clumping of bacilli, in some much more than others, but in no case did I find the remarkably thick clumping which is shown in the blood of patients actually suffering from enteric. I believe that the fact of our patients only having been inoculated once contributed to this lessening of the Widal reaction, as Dr. Wright recommends a second inoculation about twelve days after the first, but, as already stated, we were unable to carry this out. Although from a pathological point of view this omission to inoculate a second time is unfortunate, I think it proves clinically more conclusively the usefulness of the lymph, as there is no doubt our patients were exposed to infection during the entire period of the process.

I append a short table showing the ages of those attacked, distinguishing those inoculated and those not inoculated; also the ages of all who were inoculated, whether attacked with the disease or not. The result, in brief, shows that of a total of 655 who were liable to be attacked fifty-four contracted the disease—i.e., 8.24 per cent. Of the 511 patients inoculated seven, that is 1.36 per cent., were attacked after the operation. Forty-seven cases occurred, not having been previously inoculated, that is 7.16 per cent of the total liable to infection.

Age.	15	20	25	30	35	40	45	50	Total.
	to 20	to 25	to 30	to 35	to 40	to 45	to 50	to 55	
Inoculated ...	9	35	107	83	149	59	48	21	511
Contracted disease ... (previously inocul't'd)	—	2	1	3	—	—	—	1	7
Contracted disease ... (not previously inoculated)	1	16	6	6	8	7	2	1	47
									(7.16)

In connection with this table I should point out that I have made no distinction in it between the nurses and the inmates who were attacked. In looking at these two classes of patients separately it must be allowed that the insane are more liable to be attacked than the sane by a disease like enteric; their mode of life and general environment, taken together with their mental disability, render them peculiarly susceptible to any disease which is rife. Judging the results of the inoculation from this point of view (and this should not be overlooked in arriving at a decision) we find that 17 out of 114 nurses, or 14.9 per cent., were attacked, none of the nurses having been operated upon; while 37 inmates out of a possible 541 liable to attack, or 6.83 per cent., were the subjects of enteric. That is to say, more than double the percentage of sane and robust people, none of whom were inoculated, were attacked, as compared with the percentage attacked among the inoculated, all of whom were, owing to their insanity, more likely to suffer from physical ailments.

In conclusion, I should be sorry to make any dogmatic statements as to the absolutely preventive action or otherwise of inoculation against typhoid fever. If one can credit the results as evidenced among the soldiers in South Africa, enormous numbers of whom were vaccinated, it would appear to have been somewhat of a failure. There may have been circumstances in their case which militated against the success of the procedure. I cannot help thinking that it was of use in the epidemic in the

Richmond, but I shall be glad to hear the remarks of more experienced physicians than myself, who, though they probably have not had an opportunity of testing the lymph to the same extent as I have, can bring clearer views than mine to bear on the question.

## Paris Clinical Lectures.

### MEDICAL TREATMENT

OF

## CANCER OF THE STOMACH.

By CHARLES ROBIN, M.D.,

Professor of Clinical Medicine, University of Paris.

[REPORTED BY OUR PARIS CORRESPONDENT.]

[FOR FIRST ARTICLE See MEDICAL PRESS AND CIRCULAR, July 24th, 1901, page 8.]

I WILL complete to-day the medical treatment of cancer of the stomach by the consideration of remedies which relieve the symptoms and prolong the existence of the patients.

These remedies are directed either to the predominating symptoms or to the accidents which are apt to occur in the course of the malady. The symptom which immediately attracts the attention of the medical attendant to the existence of cancer, especially in elderly patients, especially if at the same time they are pale and emaciated, is anorexia or loss of appetite.

This anorexia soon merges into a positive *disgust* for food, and it is a most distressing symptom. If we know how to avail ourselves of the various means at our disposal we may be almost sure of stimulating the appetite of these unfortunate patients. As the remedies employed for this purpose are extremely numerous and vary greatly in respect of their nature and effects, I will divide the symptoms into three groups, having regard to their intensity, viz.:—Slight anorexia, pronounced anorexia, and total anorexia.

In the first series the first agent I employ is *quassia amara* in infusion, and it is on the whole a very successful treatment. If at the end of a week the appetite has not returned I have recourse to *mengante*, or water clover, which, like gentian, is usually employed in the form of a maceration. I prefer giving it in the form of wine; one drachm of *mengante* in a pint of boiling claret, and allowed to infuse twenty minutes. It is then strained and left to cool. The patient takes half a tumbler of the preparation before meals. If neither of these remedies gives satisfaction, I order tincture of *nux vomica*. In pronounced anorexia I give, a quarter of an hour before meals, a cachet containing five grains of chloride of ammonium, two grains of Dover's powder, five grains of bicarbonate of soda, and a quarter of a grain of powdered *nux vomica*.

In grave cases of anorexia remarkable results may be obtained by two new drugs, on which I read a paper recently before the Therapeutical Society, viz., persulphate of soda and metavanadate of soda. The first is given according to the following formula:—

Persulphate of soda, xv grs.;  
Water, ℥v.

A teaspoonful before the two principal meals.

Each teaspoonful contains two grains of the salt, a dose which should not be exceeded. As soon as the appetite returns the treatment should be suspended, otherwise, as Hirtz pointed out, a painful and distressing sensation of hunger is created. The persulphate given under these conditions succeeds in two-thirds of the cases.

Metavanadate of soda is even more active, and should be substituted for the preceding when, after

eight days the desired result has not been obtained. It must not be forgotten that it is a powerful tonic, and requires to be administered with prudence. The dose should not exceed one-fiftieth part of a grain, given twice a day.

Metavanadate of soda, 1 gr. ;  
Water, ʒx.

A teaspoonful represents one-fiftieth part of a grain ; two daily before meals.

By one or other of these means we shall probably succeed in restoring the appetite to the patients. But this is not all ; the patient must be able to digest what he eats. These patients secrete little or no hydrochloric acid, consequently the judicious exhibition of pepsine and hydrochloric acid is calculated to give satisfactory results. I employ a solution of hydrochloric acid (2-1,000) of which the patient takes a wineglassful in sips during the meal. I insist on this detail, which, however insignificant, has its importance ; in fact, we must endeavour to reproduce as exactly as possible the conditions of natural digestion. Now, we know that hydrochloric acid is not secreted all at once but gradually, as the food is being digested, consequently the liquid must be introduced into the stomach progressively and not in one dose at the end of the meal. The same rule applies to pepsine. It is my practice to give during the meal from three to five of the following cachets :—Pepsine, 6 grs. ; maltine, 2 grs. As a general rule, pepsine is prescribed in too small quantities, for we must remember that under normal conditions the stomach secretes enormous quantities of pepsine ; consequently, we ought always to give from twenty grains to a drachm of pepsine and two or three pills of pancreatine. The patient then should take in sips during the repast a wineglassful of hydrochloric acid (2-1,000), and four or five cachets, containing each ten grains of pepsine and two grains of maltine, and at the end of the meal two or three pills containing two grains of pancreatine.

If the artificial digestion is accompanied by irregular fermentations provoking pain, this symptom must be treated according to its nature. When the fermentation is lactic, I prescribe fluoride of ammonium, 5 grs. ; water, ʒx. Of this solution the patient will take a tablespoonful during the meal, or we may give a cachet containing iodide of sulphur, 2 grs. Such is the treatment of anorexia, dyspepsia, and gastric fermentations in patients suffering from cancer of the stomach. There is another symptom, more frequently met with, however, in gastric ulcer, which will require your attention and that is pain. The following mixture will be found useful in such cases :

Cocaine } aa 1 grain ;  
Codeine }  
Lime water, ʒv.

A dessertspoonful to be taken when the pain supervenes.

I have also been in the habit of prescribing instead of the mixture a cachet as follows :

Lactose, xv gr. ;  
Calcined magnesia, xxx. gr. ;  
Subnit. of bismuth } aa xij gr. ;  
Prepared chalk }  
Codeine, ½ gr. ;  
Bicarb. of soda, xv gr.

I must not omit to call your attention to a not infrequent accident, viz., hæmorrhage. Naturally, hæmorrhage has not the same importance in cancer as in ulcer of the stomach, but it must be borne in mind that frequent coffee-ground vomiting exhausts the patient and must be treated. Against this we may prescribe :

Tartaric acid, 5 to 10 grains ;  
Powdered opium, ½ gr. ;  
Calcined magnesia, ii grs.

For one cachet : one to be taken before each meal. If this does not succeed, which is rare, you can try against the vomiting :

Picrotoxine, } aa 1 grain ;  
Morphia, }  
Sulphate of atropine, ½ grain ;  
Ergotine, xx grs. ;  
Cherry laurel water, ʒiij.

Five or six drops about ten minutes before eating. If, however, no treatment succeeds, solid food must be suppressed, and the patient confined to milk diet.

Such are the indications and the rules for the medical treatment of cancer, and the results will be found to be to a certain extent satisfactory. Out of twenty-five patients thus treated, ten increased in weight, and their lives were prolonged by several months ; the average was 422 days.

Before closing I must say a few words in regard to the surgical treatment of cancer of the stomach, which comprises pylorotomy on the one hand and gastro-enterostomy on the other. As regards the results of these two operations, it would appear from statistics that the improvement obtained in the condition of the patient is often greater than that from medical treatment ; life is also more prolonged, the average being 507 days. Consequently each time that it is possible to diagnose cancer of the stomach at an early stage you will advise pylorotomy. As to gastro-enterostomy, which consists in establishing a communication between the stomach and the intestine, the results are less favourable, the improvement for the patient being more transitory, and the average gain in the patient being only 209 days.

## Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, August 17th, 1901.

At the Free Society of Surgeons Hr. Sonnenburg first of all alluded in suitable terms to the loss the Society had just sustained in the death of its honoured member, Hr. Langenbuch, after which Hr. H. Oppenheim related a case of

### TUMOUR OF THE SPINAL CORD.

The patient was a gentleman, æt. 40, who first consulted him in September last, complaining of pains in the left hypochondrium corresponding to the region supplied by the seventh and eighth dorsal nerves. The pains had been present for two and a half years, and in spite of all known remedies had steadily got worse. The patient's bearing was stiff, there was no kind of deformity observable in the spine, and no tenderness on pressure. On examination it struck the speaker that the patient's umbilicus was drawn a little to the right, the muscles of the left side appeared to be flabbier than the right, but it was difficult to be certain as the patient was fat. The muscles on the left did not react to faradisation, and the reflex on that side was absent, whilst it was distinctly marked on the right. A tumour was suspected on account of the duration and intensity of the symptoms, but as there was a possibility of a developing spondylitis a corset was applied. When the patient was again seen the symptoms had become worse. He could still walk, but there was weakness of the legs. There was now thermo-anæsthesia of the right leg, as well as diminished sensibility in the painful parts. Extension treatment was now begun, under which symptoms of pressure rapidly developed.

On November 12th there was complete paraplegia.

On the right the sensory and on the left the motor symptom most marked. There was retention of urine, girdle pain, and spasm in the lower extremities, and further a slight swelling of the soft parts in the region of the seventh and eight costo-vertebral articulations.

On November 17th the canal was chiselled and a tumour found at the level of the sixth vertebra and shelled out. It had grown from behind and pushed the cord on one side. The longest diameter of the tumour was 3.5 cm. It was a myxoma with partial myxomatous degeneration. The after course was at first favourable. The girdle pain ceased in twenty-four hours. In four days the urine was passed spontaneously, sensibility and motor power improved. Some days later, however, fever of an intermitting character developed, and the patient died on the eighteenth day of ascending meningitis. The cord showed a very slight constriction, but the microscope revealed ascending degeneration and diffuse disease at the site of the compression.

Hr. Sonnenburg made some technical observations, and thought the unsuccessful termination of the case was due to the temporary resection. He had the impression that the vertebral arches acted as foreign bodies and irritated the wound, whereby the outflow of spinal fluid was impeded. He would advise that the resection should not be temporary, that the first dressing should be kept on a long time, and that only the upper layers should be changed as soon as they were soaked through.

Hr. Israel had brought a case of chiselling of the spinal canal through, although meningitis did come on, and he attributed the good result to not making the resection temporary. It was a case of complete paralysis from fracture of the vertebral column. On opening the canal he found a large quantity of fluid above the compression, but none below it. A lamella of bone was found to be the cause of the compression. This was removed, and during the process of removal the dura was torn. For a week things went on well, and then symptoms of meningitis set in, with a good deal of purulent discharge from the dural sac. The dressing was renewed as often as it got soaked through, and this he thought essential, and the child pulled through. The paralysis was not relieved.

Hr. Sonnenburg discussed the subject of

#### APPENDICITIS AND TRAUMA

from a medico-legal point of view. Whether an injury could set up appendicitis had been decided by Bramann to the effect that it might if the appendix harboured a coprolite. The speaker, on the contrary, believed that trauma could excite inflammation only when the process was previously altered in structure.

The following case was very instructive:—A woman, who had had pains off and on for a long time had violent pains after a slight injury. This recurred several times, and after two years and a half led to extirpation of the appendix. Near the tip of this were found some coprolites, the mucous membrane in a state of catarrhal inflammation, and fixed by adhesions. These adhesions were caused by hæmorrhage following the injury. It was remarkable that when a trauma occurred where perityphlitis was present, the result did not correspond in severity to that of the injury. Previous disease of the process was necessary for trauma to set up peritonitis.]

Hr. v. Bergmann confirmed the views of the previous speaker.

Hr. Muhsam spoke on the

#### DIFFERENTIAL DIAGNOSIS BETWEEN APPENDICITIS AND TYPHOID.

A man was taken suddenly with obstruction, vomiting, and abdominal pain, and after temporary improvement was sent into hospital. The sensorium was then free, temp. 38.2, pulse 88. The abdomen was soft, but slightly resistant in the ileo-cæcal region. No splenic tumour and no roseola. In a few hours the symptoms became so much worse that gangrene of the appendix was suspected and laparotomy performed. The omentum was attached to the appendix, and a piece of the cæcal wall had slipped between the adhesions. The wall of the bowel was thinner at this spot, the remainder of the cæcum swollen. The mesenteric glands were also swollen. The adhesions were separated. A week after the laparotomy roseola and splenic tumour made their appearance, but neither bacteriological nor chemical test showed evidence of typhoid until the tenth day, when Purekowsky's test gave a positive result.

Hr. Sonnenburg related a case of

#### [ACUTE GANGRENOUS APPENDICITIS IN A GRAVIDA.]

Vomiting, pain, and distension set in in a woman five months pregnant. Resistance was found in the right side independent of the uterus. Laparotomy was performed, and the appendix was found gangrenous at the tip; stinking pus behind the uterus. The appendix was removed, the abscess emptied, and recovery took place, with abortion following some weeks later.

## Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, August 17th, 1901.

#### FOREIGN BODIES IN THE THROAT.

SPIBA, of Cracow, in his review of Polish work, relates a number of interesting cases. The first, a female, was admitted to hospital under Dudrewicz, with a peculiar history. While at a meal she swallowed some bread which gave her sharp pain. Shortly after she began to vomit, which rather increased the pain when endeavouring to swallow, more particularly on the left side which was tender to pressure, the pain being increased with coughing, which was accompanied with hoarseness. A week later there was blood in the sputum and saliva.

After this, a careful exploration of the larynx was made, with special attention to the seat of pain. The internal surface of the larynx was greatly swollen, more particularly the left side, and left false vocal cord. Between the Santorini and Wrisberg cartilages on the left side, just over the processus vocalis, was observed a gray coloured point which turned out to be the head of a pin. Cocain ewas applied to the inner surface of the larynx to bring down the swelling. A later examination revealed a red line below the vocal cord, indicating the presence of a foreign body. With the assistance of a pair of long forceps the head of the pin was secured and extracted, being 32 m.m. long, or 1.3 inch. The point of the pin, which was evidently swallowed with the bread, seems to have been lying free in the trachea, which would increase the pain in vomiting.

**PRIMARY INFLAMMATION OF THE MASTOID PROCESS.**

Heiman, of Warsaw, informs us that, according to his experience, very few primary cases of periostitis of the mastoid process go on to suppuration. All that do occur are of a traumatic origin, although he has had one that arose from erysipelas. All the cases he has met with have ended in resolution or thickening of the periosteum arising from severe exposure to cold, syphilis, or rheumatism. A number of the so-called primary periostitis are in reality secondary to otitis media externa or inflammation of the soft tissues in the immediate neighbourhood.

A primary periostitis of the mastoid process may be diagnosed by a hard, painful, well-defined swelling over the process, while the skin, soft tissues, aural passage, tympanum, and middle ear, are found to be perfectly healthy.

According to Heiman, primary inflammation is a very rare occurrence, although Politzer affirms that this in the mastoid process is not uncommonly met with. Injury, cold, and syphilitic origins usually commence the trouble, the inflammation of the periosteum in the cavum tympani extending later to the mastoid process. It may easily be understood from this argument that primary mastoiditis is more theoretical than clinically practical, and, furthermore, when we are told by Heiman, whose wealth of experience is extensive, that he has not met with a single genuine case, we must infer that it is a very rare occurrence.

**WASHING THE PHARYNX AND LARYNX.**

Heyng is a firm believer in the gargle, but the patient must be taught with small quantities at first to take it well back by inclinations of the head and allowing it to return by the nasal passage. The fluid should be cold at first and warm after. Ice must not be administered because of the danger of introducing microbes into an already morbid passage. Three or four ounces of the gargle should be used for five minutes at a time to be of any service, this acts on the mucous membrane as hydropathy to the skin. As a prophylactic it is indisputable when epidemics of scarlet fever, diphtheria, angina, &c., are prevalent.

There are many cases where this form of treatment is contra-indicated, such as post-diphtherial paralysis of the soft structures glosso and labiopharyngeal, and recurrent paralysis, perforation of the hard or soft tissues, perichondritis, &c., &c., where the patient has no control over the fluid and where the spray is useful. He divides the medicamenta into antiseptica, antispasmodica and narcotica, adstringentia, and resolventia. Of the antiseptics the best is a sublimate solution of 1 in 2,500; next comes salicylate and boracic, 1 in 200, and thymol, 1 in 1,500.

Zawadzki has recently been experimenting with insoluble powders and gargling with methylene blue or washing out the powders with simple water. His results were that the pharynx was never reached with a gargle, the tonsils sometimes, and the mouth always.

**KOPLIK'S SPOTS IN MEASLES.**

Strzelbicko draws attention to the diagnostic importance of "Svor" or patches on the tongue, of which Filatow first drew attention, and which recently has been confirmed by Koplik, whose name they now bear. In the late epidemic of measles in Tula eighty-four out of every 100 had well marked Koplik patches; in fifty-nine

other cases they were present forty times; in thirty cases, eighteen times; and in twenty-one cases every one. The coloured patches are not to be found on the conjunctiva or nasal membrane, only on the tongue, and this is characterised as the measles tongue. It is more evanescent than the scarlet fever tongue.

**The Operating Theatres.****KING'S COLLEGE HOSPITAL.**

**REMOVAL OF A TUMOUR FROM THE BRAIN.**—Mr. LENTHAL CHEATLE operated on a woman, *æt.* 34, who had been admitted under Dr. Aldren Turner. The patient had suffered from fits for five years; she had also complained of headache. Recently they had increased in frequency and were accompanied by left hemiplegia. They always began by slight twitchings of the angle of the mouth on the left side, spreading from thence to the rest of the face and to the left side of the body, and then the convulsion became general—evidently a typical case of Jacksonian epilepsy. Optic neuritis had been lately rapidly developing. There was some pain on thumb pressure over the right Rolandic region. These symptoms led Dr. Turner to believe there was a cerebral tumour, probably of simple nature and situated in the lower part of the right Rolandic region, and the following operation was undertaken for the removal of the growth:—A flap was turned down exposing the right side of the vertex of the skull by means of a curved incision beginning behind the external angular process, extending to the middle line at the top of the skull, and ending at the external occipital protuberance. This flap was turned down and then wrapped in cyanide gauze wrung out in 1 in 2,000 warm perchloride of mercury solution. The pericranium was then reflected, and a trephine inserted at a point where the fissure of Rolando joins the Sylvian fissure; a circular piece of bone was removed, and the trephine hole enlarged by means of bone forceps. The dura mater looked opaque and white towards the region of the frontal lobe. This appearance of the dura mater caused the operative procedures to be extended towards the frontal lobes, and necessitated turning down another flap of skin from the frontal region. Upon incising the dura mater after removing more of the frontal bone the underlying brain was incised and the finger inserted. No abnormal condition could be detected, therefore the right Rolandic region was more thoroughly explored by removing more bone. These procedures demonstrated a tumour, the surface of which was flat, hard, and superficial. It had a somewhat pearl-like appearance, its edge being abruptly demarcated from the surrounding convolutions. It measured two inches in its longest diameter (which was in a longitudinal direction), and about one inch and a half in its widest diameter. The dura mater was very slightly adherent to it. Upon reflection of the dura mater the encapsuled tumour was easily separated from the surrounding cerebral convolutions. In doing this the right lateral ventricle was opened, and cerebro-spinal fluid escaped. Only one arterial branch required ligature, bleeding from other parts being easily arrested by applying the blunt end of a needle at dull red heat. The opening into the lateral ventricle was not sutured as the convolutions fell so naturally into apposition; the dura mater was sewn up, the skin sutured, and the wound dressed

in the ordinary way. Mr. Cheatle said the success of the operation had depended entirely on the accuracy of the diagnosis originally made by Dr. Turner. The first symptoms that suggested the presence of a tumour were the left hemiplegia, the optic neuritis, the pain on thumb pressure over right side of the head, and the fits. The fact of these last beginning at the left angle of the mouth and then becoming general pointed to the tumour being in the right lower Rolandic region. Mr. Cheatle remarked that the tumour from the slowness of its growth and its encapsulation was probably benign, but that if it were sarcoma it was in all likelihood not of a malignant form, and he thought that the simple removal of the growth without any portion of the surrounding convolutions would be all that was necessary towards the ultimate cure of the patient.

It is satisfactory to state that a week after operation the woman is doing well, all her former symptoms having completely disappeared. There has been no rise of temperature.

#### CANCER HOSPITAL.

INGUINAL COLOTOMY FOR CARCINOMA RECURRING AFTER EXCISION OF RECTUM AND VAGINA.—Mr. CHARLES RYALL operated on a woman, *æt.* 48, who had been admitted into the hospital complaining of painful and difficult defæcation. Two years ago she was taken into the same institution suffering from malignant disease, implicating the lower rectum and the posterior vaginal wall; the diseased parts were then removed by the dorsal incision, sacrificing the coccyx; healthy rectum was brought down to form the posterior vaginal wall, and the new anus was placed beneath the sacrum. From this the patient made an excellent recovery, and was discharged from hospital; she had kept well until recently. She now complains of great difficulty in passing a motion, which is accompanied by great straining and much pain. There is a copious and constant discharge of mucus, with considerable loss of flesh. On examination the anal orifice was found to be stenosed from cicatricial contraction, and on introducing the finger a large new growth could be felt on the right side blocking the lumen of the bowel without any apparent destruction of mucous membrane. The vagina seemed practically normal, but in the posterior cul-de-sac could be felt the new growth which was implicating the rectum. Colotomy was considered a necessity owing to the obstruction. Eight inguinal colotomy was performed, the muscle fibres of the abdominal wall being separated and not divided. The sigmoid loop was drawn out, and a spur fixed in position by double sutures through the mesentery and abdominal wall, a single suture at either end of the wound securing the longitudinal muscular band. The bowel was not opened at the time of operation. Mr. Ryall remarked that there was no necessity to stitch the peritoneum all round the incision to the bowel, as strong adhesions took place even in a few hours, and the bowel could be opened with perfect safety if there was any distension; but patients, he said, are generally able to wait for two days before this is done. At the end of a week the stitches would be removed and the spur cut off level with the skin, after which a colotomy plug would be worn. He said that the recrudescence of the original disease was a disappointment, as the patient had kept well for nearly two years, and he drew

attention to the posterior vaginal wall which had been formed of the rectum at the first operation, and which felt like a normal vaginal wall.

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## The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, AUGUST 21, 1901.

#### SCHOOL BOARDS AND SANITATION.

THE announcement of a change in the terms of the appointment of the medical officer of the School Board of London affords a fitting opportunity for discussing the general relations that exist between educational bodies of that kind and sanitary administration. The immediate cause of the retirement of Dr. W. R. Smith from the London Board is that he could not agree with the condition attached to a rise in salary, namely, that he should “hold no other appointment except that now held by him as Professor at King’s College.” The merits of that particular demand we do not propose to discuss here, but content ourselves with the remark that the magnitude and importance of the interests involved seem sufficiently great to require the whole time and energies of any single officer. But apart from that issue there are various important points that will repay consideration. The work of the medical officer may be divided into the care of the health of teachers on the one hand, and of that of the children on the other. Candidates for teaching are properly required to come up to a fair physical standard, which is usually determined by the Board medical officer, who may or may not be required to attend the teaching staff medically during illness. The main part of his function, however, is preventive, that is to say, he has to look after the proper construction and sanitary environment of the school buildings, and to adopt measures with a view to prevent the spread of infectious diseases. In approaching this subject it should be borne in mind that the school board system is comparatively modern, so that the development of any sound system of sanitary supervision would naturally require years



of experience. It is clear that the bringing together of large numbers of children, especially in the crowded centres of population, at once multiplies greatly the chances of propagation of communicable diseases. Most public health authorities are agreed that the disastrous spread of diphtheria in recent years has been mainly due to the aggregation of children in board schools. Whether that be the case or not, it may fairly be asked what steps have been taken by the London School Board to exclude scholars suffering from sore throat. The medical officer of health may be unsparing of his energies in eradicating diphtheria from his district, but his efforts may be checkmated by the counteracting influence within his boundaries of certain board schools, where medical supervision is lax or altogether absent. This conflict of central and local health authorities is to be deprecated, as the board school is only too apt to fall to the ground between the two stools. We have always maintained that the district sanitary authority should have absolute control over the scholars so far as infectious disease is concerned, and over the sanitation of school buildings. The Salvation Army night shelters were shown to be a danger to the public health, and only after years of legislation were brought under the control of the local authority. The board schools of London have for a long time past been an acknowledged danger to public health, but they still remain under a central medical administration that apparently has never quite realised its responsibilities in the way of guardianship of the physical welfare of the scholars. The case of ringworm abundantly illustrates that retrograde position. The disease prevails to an enormous extent in the board schools of London, but we have yet to learn that any steps have been taken by the Medical Department of the Board either to eradicate or exclude the malady. There can be no doubt whatever that ringworm is spread to a degree that is well-nigh incalculable by the agency of the board schools. That fact can be testified to by all who have any experience of special hospitals for diseases of the skin or of skin departments at the general hospitals. So far from attempting to exclude children suffering from ringworm, the officers of the Board seek by every means in their power to bring pressure upon parents to send such children to school. A crop of prosecutions is directed weekly against those responsible for sufferers of that class. It is open to question whether under a carefully supervised medical system it would be possible for children suffering from this obstinate, troublesome, and costly complaint to attend school. Then, again, there should be some systematic method of excluding all doubtful cases of sore throat, to say nothing of granular lids and other infectious disorders. On the whole, it seems likely that nothing short of systematic daily medical inspection would suffice to maintain a high preventive standard. If the London School Board do not see their way to adopt a system of that kind it is to be hoped that, in their readjustment of the medical side of their

administration, they will at least take steps to remedy some of the grosser defects to which we have called attention. To maintain the wholesomeness of school buildings, and to exclude as far as possible the invasion of communicable diseases, is not the least important part of the duties of a school board, more especially in dealing with the population of the richest and largest city in the world.

#### GASTROECTASIS OF CHILDHOOD.

EVERY physician, at some time or other in his practice, meets with gastroectasis in the adult. Its diagnosis is comparatively easy. He has the history, the well-known symptoms, and his principal concern is the treatment. But when the disease occurs, as it does sometimes, in children, particularly in strumous ones, where the dyspeptic troubles are not easily traced to a state of gastroectasis, the disease is likely to be overlooked. Few medical writers on children's diseases refer to it, withal the proneness of children to dyspepsia from getting unwholesome food should put us on our guard and make us look for such. We are apt to forget that the disease is not always attended with either pain, closure of the pyloric orifice, or cancer. That it may occur suddenly and cause death in a few days without giving rise to any of the usual symptoms of the disease, even in an adult, is shown by the case of Watson and Bright, in which the patient died on the eleventh day of her illness, and the cause of death was only recognised at the examination of the body, although the stomach reached to the pubis and had given way in several places. Malnutrition and nerve innervation are more powerful factors in producing gastroectasis than pyloric narrowing; and such conditions are the outcome of dyspepsia, particularly in city-reared children. We are inclined to think that the disease would be seen to be more often noted if the cause of death in childhood were more frequently verified by post-mortem examination. In childhood vomiting is not so frequent as a symptom of the disease as it is in the adult, simply because the malnutrition of the muscular walls leaves them incapable of throwing out its contents. When the effort to vomit is made it usually ends in partially expelling the contents through the patulous pylorus, the child utters a faint cry and falls back exhausted. The belly is tympanitic, the tongue coated, the bowels irregular, often purged, the stools being liquid, with an acid, sour, fœtid smell, and the breath according to the stage of the dyspepsia may give off the smell of acetone, butyric acid, caproic acid, or sulphuretted hydrogen. If the child is stripped and placed on its back the epigastrium will be seen to rise or rather be jerked forward, from time to time as the over-distended stomach tries to empty itself into the duodenum. The wasted little body offers no difficulties in the examination, and the incessant feeble cry of pain which soothing syrups and carminatives fail to

stop, tells how much the child suffers. The condition now rapidly runs from bad to worse, for as the digestive function is more and more disordered, the natural stimulus of normally digested chyme is wanting, and the pyloric sphincter irritated by the decomposed stomach contents contracts; the contents remain bottled up in the viscus which they enlarge by distension, and the fungi, the germs of which were swallowed in the food, now finding a suitable menstruum for their growth, react injuriously on the mucous membrane. The difference between gastroectasis and dyspepsia is more one of degree than of quality; the conditions that produce dyspepsia will, if persistent produce gastroectasis. In every case the food must be such as the child can digest, and the environment of the child must be such as promotes its general health, and great care must be taken to ensure a complete convalescence after the acute diseases of childhood. We find that in the recorded cases the history of one went back to an attack of small-pox; in a second case the tardy convalescence from typhoid fever was blamed; in a third, anæmia. But the most interesting of these is M. Leven's case (Soc. Anat.) of a child nine years old, whose stomach reached to the pelvis and seemed to occupy the whole belly; the child was tuberculous, got an attack of pleurisy, from which she died, and the post-mortem examination revealed the gastroectasis, which had been unsuspected for years. Two things conspired to produce the disease in this case, to wit, the anæmia, and marasmus of the tuberculosis, and the mechanical pressure of the swollen lymphatic glands which surrounded the pylorus, and were found in the course of the gastro-duodenal artery and the hepatic. To increase the difficulty of diagnosis the disease may be closely simulated by congenital stenosis of portions of the alimentary canal as Brinton taught at the beginning of the Nineteenth Century. The lesion usually manifests itself soon after the child commences to get solid food—when it may be mistaken for intussusception or hernia. In a recent case the little patient, a girl two years old, had the principal symptoms of gastroectasis, and yet the post-mortem examination revealed a congenital narrowing of the ileum near its middle, and enormous distension of the jejunum and upper half of the ileum.

### Notes on Current Topics.

#### The Eyelid Symptoms in Exophthalmic Goitre.

THERE are two peculiarities of the movements of the eyelids met with in connection with Graves' disease to which more or less diagnostic importance is attached. Under ordinary circumstances the upper eyelid follows the movement of the globe when this is turned downwards, but in the subjects of this disease the eyelid lags behind or descends by jerks. This is known as Von Graefe's sign. It is to be noted that the upward movement of the lid does not usually present any peculiarity. Stellwag's

sign, first described by him in 1869, though it had previously be noticed by White-Cooper and Dalrymple, consists in a retraction of the lids, thus increasing the dimensions of the palpebral fissure through which the sclerotic may be visible all around the sclero-corneal margin. This retraction is most marked in the upper lid, though the lower lid also participates in the process. Both these signs exist quite independently of the exophthalmos, indeed they tend to become less marked in proportion as the proptosis becomes more evident. It must be noted also that even in cases of extreme retraction the lids, in the absence of a mechanical obstacle due to the prominence of the globes, can always be closed by a voluntary effort, only the unconscious movements being thus affected. It is difficult to estimate the diagnostic value of these eyelid symptoms in the absence of trustworthy statistics as to their frequency and duration. When present they are probably very significant of the malady, but their absence by no means negatives its existence. The origin of these signs is as yet imperfectly understood, but they have been attributed to changes in the oculomotor nuclei, a view which is supported by the comparative frequency in exophthalmic goitre of paresis of the external ocular muscles, especially of the internal recti.

#### Mirror Writing.

THE so-called mirror writing is the normal spontaneous effort to write with the left hand of a person accustomed to write with the right hand. This tendency applies equally to all movements acquired by the right hand. Without any special education the left hand reflects as in a mirror the gesture of its right fellow, so that we are driven to the conclusion that there has been a process of unconscious education of the left extremity *pari passu* with that of the right member, in other words that the training of the centre for the right hand has been reflected *en miroir* on the cortical centre for the other limb. It has been suggested that this fact should be turned to account in the case of persons who are deprived of the use of the right hand by encouraging them to adopt the plan of mirror writing with the left hand in preference to the tedious acquisition of the ability to simulate right-handed writing. It is asserted, moreover, that this training has for effect to favour the functional reintegration of the damaged centre on the other side. It is interesting to note that the readiness with which persons write *en miroir* with the left hand is in direct proportion to the extent to which they have trained the right hand. Persons of defective education, in whom the tracing of each letter entails a distinct effort of the will, are incapable of writing with the left hand, even *en miroir*, whereas those accustomed to write with fluency adopt this alternative with comparative ease.

A NUMBER of children were poisoned at Dukinfield last week from eating laburnum seeds, but the prompt administration of emetics proved successful in averting a fatal result.

### What are the Marks of a Bite?

THE question of how a wound has been inflicted is often a crucial point in medico-legal cases. The nature of the injury often affords satisfactory evidence as to the way in which it has been caused, as, for instance, when grains of powder are embedded around the entry-perforation of a bullet. At a glance it is possible, as a rule, to say whether or not the damage has been caused by a bite. The double semi-circular row of lacerations may be aptly compared to the indented marks left by an attempted bite from a hard, green apple. That there are fallacies about circumstantial evidence of the kind, however, is made abundantly clear by a recent police-court case in London. Two medical men attached to a general hospital testified that the injuries sustained by a woman were due to a bite. The chief point was the indented wounds were on both the back and the palm of the hand, and could have been caused only by pressure on both surfaces alike. Had the wounds been caused by a blow with a jagged instrument, or a stick studded with spikes or nails, only one surface would have been indented. On the other side a medical man swore positively that the wound was not due to a bite. While he admitted that the marks were something like teeth-marks in their grouping, yet from their position the teeth could not have caused them unless the assailant had the whole hand in his mouth, because of the position of the convexity of the arc. Moreover, the two series of marks did not correspond. No answer to these objections was forthcoming from the first-mentioned witnesses, and the magistrate came to the conclusion that an assault had been committed, without passing an opinion upon the conflicting medical testimony.

### The College of Safe Medicine.

THE attention of the Apothecaries' Society may be called to a certain J. C. Purdue, who figured last week at a Limehouse inquest. A baby taken to and treated by that person subsequently died of pneumonia. The bottle of medicine given to deceased was labelled "J. C. Purdue, F.C.S.M., London. Safe Medicine. Member of the Magnetic and Botanic School of Safe Medicine, London. Founded 1893. Advice gratis daily." In answer to the coroner, Mr. Wynne Baxter, Purdue stated that he was a "registered herbalist," and he explained that he made that statement on the strength of his name appearing in "Kelly's Directory." From his own admission it appears that he has been carrying on his nefarious occupation in the same neighbourhood during the past ten years, and has figured in no less than five inquests. With such a record of public experience it is nothing short of a social scandal that piratical practices of this kind should be permitted to continue year after year. In the course of his evidence Purdue alluded several times to a Dr. Meadows, and when questioned as to why he did so replied that if anyone took a child to that gentleman and said he had been to Purdue he would say "If he

can't do you any good, I can't." We should be loth to believe that any duly qualified practitioner of medicine countenanced in any way quackery so disgraceful as that of the College of Safe Medicine. We prefer to think that the bringing in of the medical man's name was simply a part of the tissue of chicanery and bluff that form the stock in trade of men of Purdue's stamp.

### Holiday Funds and Sick Children.

A SERIOUS defect in the working administration of a country holiday fund was disclosed last week in a London inquest. From the evidence it appears that a boy was sent home from a village in Huntingdonshire practically in a dying condition. On the journey he was unable to speak, and the railway guard gave him water several times. He was suffering from peritonitis, and subsequently died while undergoing an operation at hospital. The woman under whose care he had been placed stated that he had been ill for three days, and she sat up with him the night before his departure for London. She had not called in medical assistance, and had received no instructions as to what she should do in case of illness. The secretary of the society produced a copy of rules, one of which provided that if a child fell ill the country visitor should be informed at once. In this particular case he knew nothing of the woman with whom the boy had been lodged, as his dealings were with a woman of another name. This evidence points to laxity in an important matter affecting the safety of the children committed to the care of the Fund. The movement which affords town children a few days' holiday in the country is so altogether admirable that it would be a great pity were its usefulness curtailed by an oversight which appears to be one of administration rather than of organisation.

### Adrenal Therapeutics.

THE employment of adrenal extract bids fair to become a very important therapeutical departure. Experience has shown that the gland is possessed of very active physiological properties as a cardiac stimulant, and hæmostatic and contemporaneous medical literature affords ample evidence of its value in various directions. We alluded some weeks since to the possibility of remedying the non-coagulability of the blood which is the characteristic feature of the condition known as hæmophilia by the administration of the extract, and it has been successfully employed to combat uterine hæmorrhage. Its efficacy in arresting epistaxis is really remarkable, and for this purpose it is best applied on a swab or by means of a spray. It has been stated to have a marked effect in promoting uterine contraction, but this apparently does not obtain when given in therapeutical doses, for a case was recently published in which the extract was given to a pregnant woman to check bleeding from the nose and gums without any undesirable effect on gestation which went to full term, although some five ounces of the solution

of adrenal was given during the last three weeks of pregnancy.

#### Medical Research in Ireland.

THE question of medical research has been brought actively before Parliament during the last week of the Session, and in one direction with a most satisfactory result. On August 8th, Mr. William Johnston asked the Chief Secretary to the Lord-Lieutenant of Ireland whether, having regard to his reply to the deputation which waited on him in Dublin concerning a proposal to establish a pathological laboratory devoted to research in connection with insanity for the asylums of the country, he could introduce a clause into the Local Government (Ireland) Amendment Bill empowering county councils to contribute towards the support of such a central laboratory for the study of mental pathology. Mr. Wyndham replied: "Such a clause could not be inserted in the Local Government Act Amending Bill, but it would be germane to the Lunacy Bill now before the House. I earnestly hope to be able to introduce an amendment of this character into the latter Bill." It is most satisfactory to be able to record that on August 14th, on the motion of Mr. Wyndham, the following clause was inserted in the Lunacy (Ireland) Bill, viz:—"The committees for any two or more distinct asylums may agree to unite in providing and maintaining a laboratory for pathological research in connection with insanity and nervous diseases, and may defray the expenses incurred in pursuance of an agreement under this section by contributions from the funds at their disposal for the maintenance of the respective asylums." The fact that this clause was inserted in the bill without any opposition, shows that it is probable that advantage will be taken of it; indeed, we understand that many County Councils have been deterred in the past from devoting a portion of their funds to such an object solely by the fact that it was not in their legal powers to do so. We trust, however, that before any two or three asylums rush into a scheme for starting a conjoint laboratory, they will first unite with the other asylums in discussing the possibility and advantages of a grand central laboratory for the whole of Ireland.

#### Typhoid Fever in Belfast.

THE recently published minutes of the Public Health Committee of Belfast gave a serious picture of the extent and lethal character of the present epidemic of typhoid in that city. The Medical Officer of Health, Dr. Whitaker, tells in plain figures the growth of the epidemic which is very alarming. During the past month 306 cases of typhoid fever were notified, and the disease from being localised has come to prevail all over the city. Two things appear to account for the epidemic: the bad water supply and the deficient sewage arrangements for this rapidly growing and great city. The inhabitants are now fully alive to the evil, and with commendable energy the Public

Health Committee are taking steps to remedy the faulty sanitation, and get a pure water supply. And not one minute too soon, for it is an opprobrium to find that 167 deaths from such a preventible disease as typhoid fever took place there during last month. It is a difficult matter to ensure efficient sanitary arrangements in the large number of artisans' dwellings that the city contains, and to not unduly interfere with the necessary growth of such houses which the ever-increasing population of the city demands. A new water supply has now become a necessity, and altogether the condition is one calling for immediate treatment by some well considered scheme of sanitation. The citizens will have to face a heavy outlay. Belfast can be made a healthy city, as Hamburg has been made, and we have every confidence that the public spirit of its citizens will be found equal to the task.

#### The Late Small-pox Epidemic in Glasgow.

GLASGOW has now a clean bill of health so far as small-pox is concerned, the last two cases of that disease having been dismissed from Belvidere Hospital a week ago. The total number of cases has been 1,850, and of these 230 proved fatal. In connection with the late epidemic a useful object lesson has been taught the citizens of that large commercial city, as well as all other large centres of population, of the efficacy of re-vaccination in stamping out a loathsome and fatal disease. Free vaccination still obtains in Glasgow, and should be so in all large cities whether small-pox does or does not prevail. Dr. Chalmers, the Medical Officer of Health, is expected to issue a special report on the late epidemic which will be of a very interesting and instructive character. The accounts for re-vaccination have just been paid by the Corporation. In one instance a medical man received a cheque for over £300. Several accounts were over £200, and a number were over £100. The total cost has been considerable, but it is generally conceded that the money has been advantageously spent.

#### Government Grants for Scientific Investigation.

IN the House of Commons last week, Mr. Field asked the Chief Secretary for Ireland (1) whether he was aware that the English Local Government Board had at its disposal a yearly grant of funds for the purpose of promoting scientific investigation; and (2) seeing that the Irish Local Government Board had not at its disposal any sum for a similar purpose, would he recommend the placing of the Irish Local Government Board in this respect on the same footing as the similar Board in England? Mr. Wyndham replied that the vote for the English Local Government Board contained provision of a sum of money for "auxiliary scientific investigations" in connection with the medical department of the Board. He was at the time inquiring as to the special objects with which this money is voted; until he received information on this point he was unable to

reply to the suggestion in the second paragraph. We fancy that many boards of guardians would like to determine at the expense of the State what minimum amount of food per diem it is possible for a Poor-law medical officer to live upon, with the object of thus reaching the irreducible minimum of salary for the post. But apart from such purely philanthropic inquiries there are many useful problems to the solving of which money at the disposal of the Local Government Board could be devoted. *En passant*, if the English Local Government Board has a yearly grant at its disposal, would it not be spent very suitably in solving the question of the relationship of bovine and human tuberculosis?

#### Sea-Sickness and its Prevention.

THE question of sea-sickness will weigh heavily upon the mind of many a traveller during the present holiday season. This is the age of exhibitions, so we are often told, but surely there was never a more curious excuse for an "Exposition" than that of sea-sickness preventives, to be held next month at Ostend. The number of drugs vaunted for the prevention and the cure of that malady are legion, but for all that the surgeon on board ship still lacks a specific for his distressed patients, although he may afford a little relief here and there by carefully-selected remedies. Of mechanical cures there have been not a few launched by ingenious inventors upon this troubled sea of *mal de mer*, but the sea-sickness still continues in unabated flood. It is somewhat strange that the real inwardness of this familiar and distressing stomachic upheaval still remains one of the unravelled mysteries of the medical world. Perhaps the most plausible theory of causation is that which attributes it to the disturbance of the localising and balancing function exercised by the delicate semicircular canals of the inner ear. In the name of sea-sick humanity we wish hearty success to the Ostend Exhibition.

#### The Connection of Nasal Disease with Cataract.

THE importance of nasal diseases with regard to cataract is a subject which has up till now only been slightly touched upon. Professor Zieni, of Dantzig, says in the August number of the *Journal of Laryngology, Rhinology, and Otolology* that it may be assumed that by correct treatment of disease of the nose, not so much by bloodless galvano-cauterisation, especially of the middle turbinal, but by the withdrawal of blood from the nose, by the removal attended with loss of blood, of obstructive swellings or polypi, by syringing of the nose, by counter-irritations in the post-auricular space, and last but not least by the removal of febrile processes, the further development of cataract will straightway be prevented. Granting the assumption that the development of a cataract can be brought about by obstructed purulent disease of the nose as by other factors such as diabetes, &c., it would have to be further established whether the obstruction in the nose by itself would be able to accomplish the

clouding of the lens, or whether it would require the presence of a purulent disease of the adjacent cavities. The formation of cataract in such cases would have to be looked upon as being due to infection, or in some cases it would appear necessary that there should exist in addition some acute febrile trouble invariably connected with diseases of the nose, notably, for example, influenza. A striking illustration of the possible significance of febrile diseases in the etiology of cataract is to be found in the frequency of opacities of the crystalline lens in countries where febrile infectious diseases are of an endemic character, such a tract of marshy woodland for instance, as the "Sunderbunds," and also the district of Galicia. Much, no doubt, could be written on this theme, and perhaps, in the course of time, we shall live to see "Ophthalmology" added to the sonorous title of *Journal of Laryngology, Rhinology, and Otolology*.

#### Summer Diarrhœa.

IN many parts of the United Kingdom the scourge of summer diarrhœa is playing havoc among the infantile town population. In Manchester, for instance, last week's returns gave no less than 115 deaths from that malady out of a total of 316 deaths from all causes, and of the 115 diarrhœa deaths 95 took place under twelve months of age. In the same town the mortality from the epidemic in question reached 192 in the previous week. At the neighbouring township of Salford the returns for last week showed fifty deaths due to summer diarrhœa. Urmston, a residential suburb in the neighbourhood, presented a striking, not to say a startling, contrast, by having no deaths at all, either from diarrhœa or any other cause. As things stand at present the recurrent prevalence of epidemic diarrhœa is one of the gravest problems that demand the attention of public health administrators. Much has been learnt as to the bacteriology of town environment and also of the disease itself as it affects the human alimentary canal. For all that an immense field of research remains comparatively unexplored in the domain of comparative pathology. It seems likely that the key to the position lies in the direction indicated in the Milroy Lectures of 1899, namely, in the relation of town dust charged with bowel bacteria of the horse to the specific contamination of air, food, and dwellings.

#### Ankylostoma Embryos.

IN 1898 the fact was published by Dr. Looss that ankylostoma embryos can enter the skin of the human being, chiefly by the hair follicles. Dr. Looss happened on this discovery quite by accident. While engaged at laboratory work at the Cairo Medical School a drop of pure culture of ankylostoma embryos fell on to his hand. He examined the drop a few minutes later, and to his surprise he discovered numerous empty sheaths of embryos, the embryos having evidently penetrated the skin. The effect was to cause an inflammation at the spot where the embryos entered,

followed by ankylostoma infection, as shown by the fæces, with the usual symptoms of intense anæmia and extreme debility. Subsequent observation demonstrated the fact that the embryos enter the skin by the hair follicles and push their way towards the hair papillæ, at which spot they pierce the surrounding tissue of the true skin. These views were received with hostile criticism in 1898, but Professor Sandwith, of Cairo, brought the matter up again at the last meeting of the British Medical Association, and remarked on the importance of the discovery in relation to other parasitic diseases. He was supported by Col. Giles, who, however, drew attention to the difficulty of explaining the method of infecting the intestine by embryos introduced through the hair follicles. Dr. Patrick Manson discussed the matter impartially, and suggested as an efficient test that the experiments should be repeated in a country where the chance of previous infection was practically impossible. Dr. Manson's opinion that the embryo sought the hair follicle simply for the purposes of shelter will not, we think, find universal acceptance.

#### Dysentery in Asylums for the Insane.

In a lecture recently delivered by Dr. Washbourn at Guy's Hospital on the subject of dysentery, he referred incidentally to the points of relationship between the dysentery of camps and that which occurs in epidemic form among the insane confined in asylums. This serious matter of dysentery in the asylums for the insane under the London County Council has been most exhaustively dealt with by Drs. Mott and Durham in their report presented to the Asylums Committee. The report shows that there was distinct evidence of spread of infection from bed to bed owing to the dirty habits of the patients, the imperfect arrangements as to personal cleanliness of patients and cleansing and disinfecting of their bedding, and the serious overcrowding of the dormitories. From the description given there can be little doubt that this asylum dysentery is identical with the camp dysentery of the South African campaign; there is the same type of fever and similar symptoms. Moreover, according to Dr. Washbourn, the post-mortem appearances are identical with this exception—that acute cases sometimes die before ulceration has occurred, a condition which he had not observed in South Africa. It has been held that the cases described by Dr. Hale White under the names of simple colitis and ulcerative colitis were really sporadic cases of the dysentery reported on by Drs. Mott and Durham to the Asylums Committee of the London County Council. The conclusions to be drawn seem absolutely clear, that this disease is ascribable to insanitary conditions, that it is infective, and that it can be prevented to a certain extent at the war, and to a very large extent indeed in institutions where we have a right to expect that the greatest care should be exercised to protect the helpless inmates against

infective maladies arising from overcrowding and dirt.

#### Operation under Accidental Hypnosis.

THOUGH operations on patients under hypnotic influence is no new thing, it certainly has not happened to many medical men to repair a vesico-vaginal fistula with the patient under complete anæsthesia obtained accidentally and without premeditation. The facts are given in the *St. Paul Medical Journal* for May, and it is explained that the patient was of a yielding nature, and implicitly obeyed any instructions. The parts in the neighbourhood of the field of operation were infiltrated with a 2 per cent. solution of cocaine, and the woman was told she would have no pain and must keep absolutely quiet. She obeyed so thoroughly that it was quite forgotten for some time that the operation was being conducted without a general anæsthetic. In the course of the proceeding the practitioner had occasion to make some remark to the patient, when it was noticed she made no answer; she was on examination found to be sleeping soundly, with normal colour, pulse, and respiration. On being awakened she complained of feeling sleepy, and sank back into a sound slumber on a few passes being made over her face. She suddenly woke as the last suture was inserted, and left the consulting-room after the operation still complaining of sleepiness.

#### The Forerunners of Tuberculosis in Synovial Sacs.

THE examination of a number of tuberculous joints reveals a considerable thickening of the walls of the vessels of the synovial membranes. This, however, is only apparent, for the thickening is really the result of diapedesis of white cells followed by a deposit of fibres and organisation of connective tissue forming a sheath round the vessel. This sheath encasing the walls of the vessels reduces their elasticity and affords an explanation of the tendency to bleed that characterises tuberculous synovial membranes. Dr. Dieterichs, who describes methods of investigation in *Vratch*, believes that the circulatory disturbance and the formation of the connective tissue sheaths are the forerunners of tuberculosis in these tissues.

#### Dissemination of Disease by the Secretions of the Mouth and Respiratory Tract.

IN the coughing of phthisical patients, even in hospitals where every possible attention is given to hygienic matters—ventilation, light, and the proper disinfection of sputum—we may possibly find an explanation of the fact that patients in the early stages of the disease often do so badly. By an ingenious mask (*New York Medical Journal*, July 27th, 1901) holding a microscopic slide in front of the mouth evidence has been collected to show that the secretions of the mouth and respiratory tract are atomised and given off in the form of a ray in both health and disease. There can

be no objection raised to the conclusion that diseases affecting the mouth and respiratory tract are spread in this manner, as for example diphtheria, scarlet fever, and pertussis. Proof is thus afforded of one means by which clothing on which a patient has coughed may serve to convey disease from house to house, and of the danger of infection to man from the salivary spray of horses, cows, dogs, and cats suffering from certain maladies.

#### Alleged Hospital Neglect.

A CORONER'S jury last week passed a censure upon the authorities of St. Thomas's Hospital. The facts of the case, as disclosed at an inquest in the City of London Court, showed that a woman of 49 was admitted to the hospital after taking a pennyworth of salts of lemon. She was discharged from St. Thomas's a week later, and removed in the custody of the police to the Southwark Police Court, whence she was remanded to Holloway Gaol. On arrival at the prison she was immediately removed to the infirmary, where she died three days later. Medical evidence showed death to be due to acute broncho-pneumonia and Bright's disease. There can be little doubt that most unfortunately the woman was sent from the hospital in an unfit condition. From one report we gather that the patient was discharged by the house physician without a proper physical examination, and that the urine was untested during the whole stay at St. Thomas's. It is to be hoped that the authorities will take steps to prevent the recurrence of such an untoward affair in future. The duties of a house physician are harassing and responsible in the extreme, and it would be preferable to leave the discharge of patients to the care of the police to a medical officer with more leisure and experience at his command.

#### The Toxicity of Camphor.

CAMPHOR is such a popular drug that its comparative toxicity is very apt to be lost sight of. That it is a poison is proved by the death of a child at Huddersfield after swallowing two drachms of camphorated oil, equal to about thirty grains of the drug. Dr. Murrell, in his admirable little work, "What to Do in Cases of Poisoning," states that though camphor often gives rise to alarming symptoms, it rarely proves fatal. The lethal effects are apparently somewhat uncertain, this being due no doubt to its slight solubility, which gives time for the adoption of remedial measures.

#### Testevin's Sign.

THE diagnostic sign which is generally known by the name of Testevin has been lately the subject of patient investigation by Modena, of Pavia, who has lately published the record of his observations. The sign of Testevin is sought for in urine in the following manner:—After removing any albumin, if present, a specimen of the child's urine is slightly acidified, some ether is added, and the mixture well shaken. In a more or less short period of time a small pellet described as having the appearance of collodion is found to float on the

surface of the fluid. It is stated that the substance varies in regard to thickness, consistence, and adhesiveness. It is accepted by many as a characteristic sign of infection during the incubation of acute and chronic infectious diseases, and the more pronounced is this peculiar reaction the greater is supposed to be the severity of the infection. Modena has found it in cases of infectious diseases, but does not consider that it is of any value from the point of view of diagnosis or prognosis.

#### A Mixed Metaphor.

A WRITER in the *Morning Leader* in the course of an eloquent article upon the war, made use of some dental metaphors which show considerable confusion as to the scope and meaning of certain operations connected with dental surgery. "Some day," he says, "we suppose truth will out, but it is a very tedious process, extracted like the filling of a double tooth under the shadow of persistent criticism, and even then one cannot be sure that the whole is in the grip of the pincers." Filling and extraction, it may be pointed out, are two entirely different processes, and both are carried out under the fullest light obtainable. In the writer's mind, however, the dental profession is probably associated with the grip of the forceps to an extent over and above every other aspect of that learned craft.

#### Amyloid Disease in Horses Immunised against Diphtheria.

EXPERIMENTAL study of amyloid degeneration found in horses during the process of immunisation shows a diffuse visceral amyloid degeneration, especially of the liver, with hepatic and intraperitoneal hæmorrhages due to rupture of the liver and fatty degeneration of parenchymatous organs. In the opinion of the investigator, Dr. Zenoni, the horse should be carefully watched for the development of symptoms of amyloid disease, which are shown clinically by exhaustion, want of appetite, loss of flesh, and rapidly increasing anæmia. Unless the injections of toxin are suspended forthwith the animal becomes jaundiced, fever supervenes, prostration becomes marked, and finally collapse is followed by death.

#### Koch versus Alimentary Tuberculosis.

THERE is satisfactory evidence, not only in this but also in most other countries, that the precautions at present in force to prevent the sale of the flesh and milk of tuberculous animals are not to be abandoned in deference to Professor Koch's recent utterances; indeed, the manner in which these views were brought forward has given rise in more than one influential quarter to the expression of very strong opinions. We note with satisfaction that the great dairy companies will continue their efforts to secure the freedom from disease-producing organisms of their milk, and we may take it for granted that local sanitary authorities will not fail to apply the powers vested in them with the same object in view.

### The Sterilisation of Milk.

FEARS have been expressed lest farmers and dairy-men should become careless in view of the facilities for preserving milk afforded by the process of sterilisation. Although this fear is hardly likely to be realised it cannot be too strongly impressed on producers and consumers alike that boiling does not confer upon stale milk the dietetic properties of fresh milk. True it kills all living organisms, but it does not rid the milk of the products of bacterial activity to which many of the ill-effects of stale milk on the young are due. A milk which has been boiled at a stage of bacterial activity is very apt to set up acute gastro-intestinal disturbance, and is from every point of view an undesirable article of food. To be of value the process of sterilisation must be carried out very soon after the milk is withdrawn, and thenceforth special precautions are necessary to prevent its becoming contaminated from the outside.

### The Growth of the Hair in the Insane.

A FRENCH alienist has remarked by a comparison of the growth of the hair in normal and insane women that the growth of the hair is much more pronounced in the latter than in the former, and the phenomenon is specially well marked in the victims of senile dementia and general paralysis. He even goes so far as to regard a profuse growth of hair as an indication of physical degeneration, due, in all probability, to functional disturbance of the thyroid gland or the ovary.

### The Sanitary Institute.

THE next Congress and Exhibition of the Institute will be held in the city of Manchester in the second week of September, 1902, under the presidency of the Right. Hon. the Earl Egerton of Tatton.

THE little town of Raunds, in Northamptonshire, is suffering from a serious outbreak of typhoid fever. The Medical Officer reports that seventy-five cases of typhoid have occurred in a fortnight, most of them being of a very serious character, and traceable to a well supplying 200 families, which had been polluted by storm water.

### PERSONAL.

DR. ROBERT WELSH BRANTHWAITE has been appointed Inspector of State Inebriate Reformatories, a post which is likely to be more or less a sinecure for some years to come, judging from the progress accomplished so far in providing these much-needed retreats.

DR. EDMUND GWYNN has been presented with a pair of silver candelabra and a silver bowl by the medical practitioners of Hampstead, on the occasion of his retirement from the post of Medical Officership of Health. The presentation was made by Dr. Ford Anderson. Dr. Gwynn was also presented with a set of four silver bowls by Professor Stokes on behalf of his colleagues on the Hampstead Borough Council.

DR. WILLIAM HANNA, M.A., M.B., B.U.I., D.P.H.

Camb., was elected Assistant Medical Officer to the Port of Liverpool on the 1st inst. by the port sanitary authority. Dr. Hanna studied at Glasgow, Cambridge, and Berlin. These studies were supplemented by an experience of three years on plague duty in India, and in the investigation of tropical diseases at the Government Research Laboratory, Bombay.

DR. W. TAYLOR, Chief of the Army Medical Department in India, who has now been appointed to the headquarters of the Royal Army Medical Department in London, will not take over the duties for some six weeks. Surgeon-General Taylor, directly he joins the Headquarters Staff at Victoria Street, will be chiefly engaged in carrying out the further reorganisation of the R.A.M.C.

A GREAT ovation was accorded on Friday night at Manchester, when thirty men of the Manchester Volunteer Medical Staff Corps returned to the city from the seat of war in South Africa, after an absence of twenty months. The crowd was so great and the enthusiasm so demonstrative that they had the greatest difficulty in reaching headquarters, where the officer commanding the corps (Surgeon-Colonel Coates) subsequently addressed a few words of welcome to them.

DR. PAUL GAERNAULT, of Paris, has suddenly leapt into world-wide fame by his offer to test upon himself Dr. Koch's theory of the non-transmission of bovine tuberculosis to human beings. He has written to the German Professor offering to undergo inoculation with bovine tuberculous material. Dr. Garnault states that he is forty-one years of age, that he weighs over 100 kilograms, that his height is 1.81 metres, that his health is perfect, and that he has no children.

## Correspondence.

[We do not hold ourselves responsible for the opinions of our correspondents.]

### THE DIFFICULTY OF DIAGNOSIS IN INFECTIOUS DISEASES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR.—The highly speculative conditions to which medical men are exposed in the diagnosis of disease subject to notification, and the responsibility, both moral and legal, thereby incurred, render the question of more or less considerable moment. The difficulty is no doubt intensified among those practitioners whose lot has cast them among a nest of the less opulent classes whose circumstances are such that nothing save dire necessity or anxiety prompts them to seek medical advice until the appearances may seem to them to indicate gravity. Hence in many of these cases the landmarks to diagnosis in any rash, &c., which may or may not have appeared, have become effaced, and the practitioner is often driven to the wildest conjecture as to the original nature of the disease. Taking the law, however, as we find it there can be no doubt as to the advisability of granting considerable latitude towards medical practitioners in their discretionary ability and onerous duties with regard to notification. I have heard it stated, and this on authority too, that medical men in the present day notify rashly, and the officials, therefore, should act with extreme caution before applying any oppressive measures in attempting to uphold the law in the event of any supposed breach, otherwise the procedure would



tend to stimulate timid members of the profession to carry on notification to an extreme degree which, as I have just stated, has already been suggested on authority.

Returning to the point concerning the difficulty of notification I may mention a few cases within my own knowledge. On one occasion a domestic servant whom I attended came to the house on the day following, and appeared to be suffering from chicken-pox. Although the case as I thought was anything but typical, nevertheless it flashed across me that it might be one of small-pox, however, there happened to be little or no constitutional disturbance, and as there was a fair sprinkling of rash on the face I concluded that the general state of health was inconsistent with an attack of small-pox seeing there was, as I have said, some amount of rash. The maid, however, was sent home and a local practitioner called in, as also another, presumably in consultation, both of whom notified the disease as small-pox. Feeling reasonably certain that a mistake had been made, I called on the medical officer of health and likewise at the ambulance station, and through the courtesy of the official at the latter department, I was informed by letter that the case had been returned in a few days chicken-pox.

On another occasion quite recently I was fetched to see a child suffering from throat affection, and as there appeared some herpetic eruption on the lips I believed the case to be catarrhal, and calling the following day thought the same. On the third day, however, I was surprised to find the child at play in the garden, and on examining the throat on this occasion a tough-looking piece of membrane appeared on the tonsil, which I concluded was diphtheria, and explained the necessity of notification, but the husband not being at home I suggested for satisfaction calling in another local medical man; whereupon the mother remarked to me in a confidential tone that her husband was "a funny man," after which she went on to explain that the husband had actually taken the child to the surgery of another practitioner during my attendance, and that he pronounced it cold, probably from the same reason as I, viz., the herpetic eruption. As, however, opinion was set against opinion, I suggested striking the balance by calling in another, but on the arrival of the husband home the same medical man was consulted, and on this occasion he notified diphtheria. A point of interest seems to me to consist in this, viz., that supposing the medical man in question had had no opportunity of seeing the case the second time a *prima facie* suspicion of non-notification might present itself, and indeed a prosecution took place, and was referred to in your columns, in one point analogous to this, inasmuch that in both they were taken for examination to a surgery.

On yet another occasion, and this recently too, a child was brought to me apparently suffering from scarlet fever—at least the rash was identical—sore throat, and the faintest, if any, catarrhal symptoms, but fortunately notification was delayed, and in three days' time it turned out an unmistakable case of measles.

I have mentioned these instances merely to illustrate the difficulties involved in notification, difficulties, too, which may not be so readily appreciated by those in high places. How far notification may have decreased mortality, or to what extent isolation has reduced the number of infectious diseases, is a problem perhaps not easily solved, as the evidence is complex, but with regard to isolation it would appear that if any disease of an infectious type invade a house, in the majority of cases other members of the household seem to contract it.

Every medical man in a populated district must be aware of the fact how frequently infectious diseases are brought to the house, and we may thereby infer that if notification and isolation are what they purport to be or anticipate, and of the importance that they appear to merit, the sooner the system of allowing druggists to prescribe be stopped the better for the public interest, otherwise the effects of the Act must, to a greater or less degree, be nullified, because we may be certain that a percentage of mild infectious cases escape detection

through falling within the meshes of their nets and due to their direct or indirect prescribing.

I am, Sir, yours truly,

CLEMENT H. SEES, M.B.C.S., L.B.C.P. Edin.

P.S.—I must mention that in the case of diphtheria referred to above other members of the household were notified, and an infant died, but not under my care.

"LATENT CERVICAL FRACTURE"

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Will you please say for the satisfaction of your readers, How could force sufficient to break the transverse process of the fourth cervical vertebra be applied so as to leave no external mark?

Could such a fracture result from muscular force?

What is Simon's definition of a "latent" fracture?

How many such fractures are on record?

I am, Sir, yours truly,

CLEOFAS.

[From the published report of the post-mortem examination evidence of subcutaneous extravasation of blood led to the examination of the posterior cervical region. A fracture of a transverse process of the fourth cervical vertebra is not likely to result from muscular action. Lidell's definition is as follows:—"In the examples of so-called latent fracture of the vertebræ the spinal cord is not at all affected by concussion, nor by contusion, nor is it compressed by displaced bone, nor by extravasated blood." We have not Simon's definition before us. To ascertain the number of recorded "latent" fractures of the spine would involve a tedious and laborious investigation.—Ed.]

THE PROPOSED BRITISH AND COLONIAL JOURNAL OF OBSTETRICS AND GYNÆCOLOGY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In a somewhat lengthy letter, Dr. Sinclair seems to me to miss the one point which was necessary. There is undoubtedly a feeling that the British Gynæcological Society has been thrown over in favour of the Obstetrical Society, and I would suggest that Dr. Sinclair should let us know how many Fellows of the Gynæcological and how many of the Obstetrical Society were invited to the preliminary meeting, noting at the same time how many Fellows of each society asked practice in London. By doing this Dr. Sinclair will at once show how things stand, and if he does not do it, I, for one, will draw my own conclusions.

In a letter of three lines Dr. Sinclair can settle the relation of the proposed journal to the two societies.

I am, Sir, yours truly,

SKENE KEITH.

London, August 20th, 1901.

MR. PEREGRINE PURVIS has sent a donation of £1,000 to the Royal Free Hospital, London.

MESSES. T. B. SHAW, M.B., P. T. Nicholls, A. T. Gailton, M.B., and G. S. Davidge have been gazetted surgeons to his Majesty's fleet, with seniority, of August 10th.

Royal Army Medical Corps.

SURGEON-CAPT. C. DALTON, embarked at Liverpool on Saturday last for Sierra Leone. A draft of 100 men embarked at Southampton on the 19th inst., on the s.s. *Canada*, for South Africa. Surgeon-Major G. Tuke joined at Woolwich on the 10th inst. Lieut. Davies and Lieut. A. W. Gibson have been posted to the Cambridge Hospital at Aldershot for duty. Surgeon-Major Dodd has assumed temporary charge of the Connaught Hospital at Aldershot during the absence of Lieut.-Col Wilson.

## Literature.

### SENN'S "PATHOLOGY AND SURGICAL TREATMENT OF TUMOURS." (a)

THE second edition of Professor Senn's book on "The Pathology and Surgical Treatment of Tumours" forms a substantial volume. The illustrations are very numerous and, on the whole, well selected. Many of those representing histological details are excellent. A very liberal use has been made of italics in emphasising important points in treatment and in the definition of terms. The successful surgical treatment of tumours depends, probably more than other branches of operative surgery, on the resourcefulness of the surgeon rather than on the remembrance of any formulated rules. In the book before us the operations described are those which have been found most generally useful, or which serve to illustrate some great principle in operative surgery. The general medical reader is not confused by an exhaustive descriptive list of operations.

The direction is given in italics on page 408 that "the removal of a subcutaneous lipoma must be done under strict aseptic precautions," and special reasons for this are then given. The inference is only too likely to be drawn from such statements that in operations on other forms of tumour in which these special anatomical conditions are not present strict asepsis is not necessary or essential. Practice based on such a belief must result, sooner or later, in what would be considered lamentable results.

Multiple false neuromata and molluscum fibrosum are regarded as synonymous terms. Even allowing that molluscum fibrosum be connected with, or even directly the result of changes in the nerves of the skin—and this seems to be as yet non-proven, it is almost indispensable for the clear understanding of their clinical features that the two conditions should be distinctly marked off from one another. It will be pretty generally conceded that *clinically* the two conditions are distinct, consequently it seems undesirable to place them so closely together as Professor Senn does. We have noticed confusion in other American textbooks in the descriptions of false neuromata and molluscum fibrosum. The terms macroglossia and macrocheilia are restricted to lymphangioma of the tongue and lips. It is well to thus limit the applicability of these otherwise indefinite terms.

### OPPENHEIM'S NERVOUS SYSTEM. (b)

WE have here not a first appearance, but a well-known and well-established work, now in its second edition, of which it may be well to give some fuller detail than usual of the scope, purpose, and style. The author's main idea is to block it at the outset into two main parts, viz., the general part and the special part. In the general part, of course, the subject is opened up in general terms, the reader is led through the simpler and broader pathways of knowledge of the subject as they first present themselves, and from the point of view of height and breadth has the general differentiation of the great nervous system at an advantage. Methods and modes of examination may be said to comprise the first part of the work, and here undoubtedly there is more to be said than appears on the surface. The author lays stress on the importance of methodical detail, in the methods of examination, of the beginner; but he does not think the experienced examiner requires a fixed order of examination. We join issue here, for the success of our young physicians is due to the fact that they are still methodical, and the failure of older men, who now lag in the paths of research, is due to the fact that "the gold coast" is too attractive, and time to a busy consultant means money. Of course, we make exceptions to this statement. We agree with the author that the question of heredity should find a

first and important place; but sometimes this takes up a long time, and the consultant trusts to his experience to pass it by. We believe this is a great mistake. The author is rather hurried in dealing with the anamnesis, and he sums up the most important inherited diseases without any discrimination. A thorough and sound descriptive article on the evolution of the neurons would be most instructive and valuable, and full of suggestion for practical uses. It is not enough to tell us that "morbid inclinations to suicide, alcoholism, &c., indicate a neuropathic diathesis." There is too much begging of the question here. Again, much more might be said of the diseases which predispose to nervous affections, and certainly the statement regarding consanguineous marriages is a very meagre one. It requires a chapter to itself. It is not usual for writers on diseases of the nervous system to insist that a knowledge of psychiatry must always accompany, if not precede, that of neurology. In this country such a statement is usually conspicuous by its absence. It is, nevertheless, a sound expression of opinion, and applies to the whole gamut of disease as well. The author goes very fully into the question of the stigmata of degeneration, the skull, ear, teeth, palate, &c., but very wisely makes this reservation, that "too much importance should not, however, be given them, as almost all may occur in perfectly normal individuals." The general symptomatology of the muscular system receives a very considerable share of attention, but more explanatory references are needed. The minute muscular system of face, eyes, tongue, larynx, &c., is here fully treated of. We come now to the second or special part, which is mainly taken up with spinal, brain, and peripheral diseases, and practically occupies the chief portion of the book. The anatomical description, especially microscopic, of the spinal cord, is very good, and, of course, much of it is repetition; but that is unavoidable. What the student and practitioner will most appreciate is the fresh light which is thrown upon function, especially the reflexes. Beginning with the system diseases of the spinal cord, we find locomotor ataxia heads the list. We find also here, as elsewhere, that the author is by no means redundant in his descriptions, and that little space covers a good deal of matter. On the subject of treatment Oppenheim is more communicative than some others. He evidently has something to say worth taking note of, and he is evidently more hopeful of results in the early treatment of this wretched disease. Into descriptions of neuritis and multiple neuritis the author enters with much detail and discrimination, but on the subject of craft paralysis we think he might have said more. On introducing the section of diseases of the brain, a brief anatomical description is given. A brief, but fairly satisfactory, reference is made of the localisation of function, but though with some slight equipment to introduce the clinical description the reader is referred to other and fuller details, so as not to over-write this book. The general phenomena of cerebral disease are here classed under two heads (a) those representing organic disease, (b) those representing functional disease. Into these, here and elsewhere, the author enters with great care, and this part of the work will be found most interesting and practical. The method adopted here is very good. Under the title of local symptoms, Oppenheim treats first of symptoms of irritation, beginning with the cortical motor zone, and treating of localised spasms, including Jacksonian epilepsy. From symptoms of irritation he passes on to paralysis, but here, though he is on practically the same ground, the author is not explicit, and does not distinguish plainly. Space forbids us to linger here longer, but we commend all this to the reader, especially the section on speech defects, which is not too long. A long series of excellent chapters appear on the diseases of the meninges, the brain substance, &c., and here, as elsewhere, it might be expected that more might be written. The well-read and experienced student and practitioner, however, will read and know between the lines much more than appears on the surface. He will find here much valuable help, especially

(a) "The Pathology and Surgical Treatment of Tumours." By W. Senn, M.D., Ph.D., LL.D., Professor of Surgery, Chicago Polyclinic, Rush Medical College, &c. Second Edition, Revised. 8vo. Pp. 718. Illustrated by 478 engravings and 12 full-page plates in colours. Philadelphia: W. B. Saunders, 1900.

(b) "Diseases of the Nervous System." By H. Oppenheim, M.D. Philadelphia and London: J. P. Lippincott and Co.

in the differential diagnosis of many difficult and obscure brain diseases. Coming near a close the author in Section IV. takes up the neuroses. A brief introduction on the term Neuroses would have been useful. The term is much read; its definition is not clear, nor are its limits well understood. Here he plunges right away into hysteria. Why? We know not; but we do know that we heard of hysteria long before we ever heard of "The Neuroses." We are not even clear yet as to how much of so-called hysteria is neurosis, and how much is not. As regards the proportion of women and men relatively affected, we agree with the author that the figures of Briquet must be modified. This section from its Continental origin is sure to have something new for many of our readers, and we would specially direct attention to hypnotism, neurasthenia, phobias, &c. The remaining sections, dealing with diseases of the sympathetic nervous system, angioneuroses and euphorooses, and with neuro-toxæmias are very important, but rather short. The illustrations are very appropriate, and altogether the work is well worthy of a place in English medical literature.

LEFTWICH'S INDEX OF SYMPTOMS. (a)

THE idea underlying this little work is ingenious, and we may infer from the fact that it has reached a second edition that the author's scheme has met with a favourable reception. The contents are divided into the main chapters, one of symptoms ascertained by interrogation and another of symptoms discoverable by physical examination. The method is the same throughout; under the head of a particular symptom is given a list of the various conditions or diseases to one or other of which it may be due. In practice this leads to some rather startling *rapprochements*. For instance, under "sleeplessness" we get as possible causes collapse of lungs and trichinosis, while under "night terrors" we have mucous disease (?) and frights. Some of the references excite surprise, for example, "bulimia" is associated with exophthalmic goitre, iodism, and whooping-cough, while anorexia is described as possibly due to cancer of liver or stomach, cystitis, empyema, &c. Really we fail to see what possible assistance such references can afford in arriving at a diagnosis. Of course all the lists are not equally wide of the mark, and herein lies the value of the work. The more special the symptom the greater the value of the list which it precedes. The book concludes with a useful little chapter on methods of diagnosis for the use of clinical clerks, &c. and it is illustrated by seven figures. We can quite believe that the work has entailed upon the author a large amount of patient work, we only fear that the result may not be found commensurate with the labour and energy devoted to it.

GOODSALL'S ANUS AND RECTUM. (b)

THIS book commences with an excellent chapter, fully illustrated, on the anatomy of the parts; the second chapter is on general diagnosis, and gives some very practical suggestions for questioning and also for examining the patient. The chapter on abscess comes next, and opens the way for the one on ano-rectal fistula, which is not only profusely illustrated but constitutes in itself an exhaustive treatise on the subject, occupying 81 pp. Recto-urethral, recto-vesical, and recto-vaginal fistulae are more lightly dealt with, but sinus over the sacrum, a condition the literature on which, the authors point out, is very limited, is more fully entered into, some illustrative and illustrated cases being given which much enhance the authors' explanation. The description, position, aetiology, symptoms, diagnosis, and treatment of anal fissure is next given, together with a graphic account of the two principal operations for its relief. The last chapter is devoted to

external and internal piles. With regard to the latter the authors have a very strong preference for ligature (Salmon's operations), and give their reasons for objecting to the other seven methods of operation. Altogether this first volume, though containing nothing particularly new, is well worthy of perusal, if only for the very graphic illustrations, and we look forward with pleasure to the advent of Part II.

GANT'S MOCK-NURSES. (a)

THE second edition of Mr. Gant's book is supplemented by an interesting auto-memoir of the author, which takes the reader back to the beginning of last century, with reminiscences of Eastbourne, Hastings, and St. Leonards, then merely villages, next on to the Crimean War, with glimpses of Balaclava, Inkerman, Scutari, &c., culled from Mr. Gant's experiences when acting as one of the civil surgeons to the troops, and finally to the author's long connection with the Royal Free Hospital and the evolution of that institution into the practical medical school for women. A review of the first part of the book has already appeared in our columns.

BICHAT'S GENERAL ANATOMY. (b)

THIS is the first fasciculus of the re-edition of Bichat's work—a work of positive philosophy—and conforms to the spelling, punctuation, &c., of the 1801 edition. The plan of the work is to consider by itself each of the single systems which by their different combinations form the human organism; the base of this plan is anatomical, but the details it embraces belong also to medicine and physiology. The several doctrines put forward are opposed to those of Boerhaave, and differ from those of Stahl and his followers. After some general considerations the author deals with the cellular system, with the nervous system, and with the vascular system, all of the subjects being treated in a philosophical manner and the whole fasciculus is interesting as an abstruse study.

MANSELL MOULLIN'S WHEN TO OPERATE IN INFLAMMATION OF THE APPENDIX. (c)

THESE four lectures, which were originally published in, and reprinted from, the *Clinical Journal*, and which have been revised and partially rewritten for the present edition, can be read with advantage by every medical man. Mr. Mansell Moullin is evidently an advocate for operation in nearly all cases of inflammation of the appendix, and his reasons are so straightforward and his arguments so convincing that his words should go a long way towards converting those who are more in favour of expectant treatment.

HALLS' DISEASES OF THE NOSE AND THROAT. (d)

WE have read this book with great pleasure. The style is clear and concise, and the descriptions are graphic. The information is up-to-date; the volume contains more than enough for general practitioners familiar with the use of the laryngoscope; and it may be described as an excellent text-book for students beginning the study of the subject.

We heartily endorse the condemnation of the removal of the inferior turbinated bone by the spokeshave; an operation of which we were among the first to disapprove, as likely to be followed by troubles worse and less easily treated than the condition for which it was proposed,

(a) "Mock-Nurses of the Latest Fashion, with a Short Memoir of the Author." By Frederick James Gant, F.R.C.S. Pp. 253. Second Edition. London: Baillière, Tindall, and Cox.

(b) "Anatomie Générale Appliquée à la Physiologie et à la Médecine." Par Xavier Bichat. Première Partie, G. Steinheil, Paris.

(c) "When to Operate in Inflammation of the Appendix." By C. Mansell Moullin, M.D., F.R.C.S. Second Edition. Pp. 39. John Bale, Sons, and Danielsson.

(d) "Diseases of the Nose and Throat." By H. de Havilland Hall, M.D., F.R.C.P., and Herbert Tilley Lewis, M.D., Lond. F.R.C.S. London: H. K. Lewis.

(a) "An Index of Symptoms as a Clue to Diagnosis." By Ralph Wigginton Leftwich, M.D., late Assistant Physician to the East London Children's Hospital. 2nd Edition. London: Smith, Elder, and Co. 1901.

(b) "Diseases of the Anus and Rectum." By D. H. Goodsall, F.R.C.S., and W. Ernest Miles, F.R.C.S. (in Two Parts). Part I. Pp. 51L. London: Longmans, Green, and Co.

not to speak of the danger from hæmorrhage during and immediately after its performance.

We are glad to see that the "head down" position for removal of adenoids is here advocated. So far as we are aware, all the deaths from this operation have occurred during its performance with the patient in the upright position, either from syncope, from chloroform, or from drowning by blood. These dangers are obviated, or reduced to a minimum, by the "head down" position, and we have no doubt that this method will beat the older one out of the field.

There is little in the work for adverse criticism. The statement at p. 142, that "the sense of smell is at least twice as acute in man as in woman," does not accord with our experience.

#### THE THERMAL WATERS OF BATH. (a)

THIS small book not only gives an account of Bath and the development of its now splendid bathing establishments, but also gives much information on the use of massage, with or without the waters, that will be found very useful by a large class of invalids. The author claims, and we think quite correctly, that the Bath waters, aided by judicious massage, can do quite as much good in cases of dilated heart as can be accomplished by the Naheim treatment. The observations, at page 29, on this subject are well worth study.

In his concluding chapters the author does not shirk statistics. In rheumatoid arthritis he gives 5 per cent. as cured and 80·7 relieved. No one knowing anything of the complaint will think such results unfavourable. Of cases of true gout treated 13·9 were cured and 80·7 relieved.

The appendix which closes the book affords information as to charges and fees for the baths. Though small and of very moderate cost the book is very full of interest and instruction, and everyone contemplating a visit to Bath will do well to get a copy, and will find the perusal well repay him.

#### TUBBY'S INTRA-ABDOMINAL SUPPURATION. (b)

THIS little book comprises seven clinical lectures delivered at the Westminster Hospital, of which four are devoted to Appendicitis, one to Sub-diaphragmatic Abscess, one to Pelvic Suppuration and Tuberculous Peritonitis, and one to General Peritonitis. The four lectures on Appendicitis are very practical. They include: Anatomy, Pathology, Bacteriology, Ætiology, Symptoms, Signs, Complications, Sequelæ, Diagnosis, Prognosis, Treatment, and should prove especially useful to students who eventually take a country practice. The next lecture on Sub-diaphragmatic Abscess is well worthy of perusal, the symptoms and signs being very clearly given, particularly those in connection with an abscess of this kind caused by perforation of the stomach. The last two lectures are fully up to the mark of the first five, and Mr. Tubby is to be congratulated on having placed before the profession in book form so much instructive matter.

#### ALLCHIN'S MEDICINE.—PART II. (c)

PART II. of this important manual sustains the opinion expressed on the appearance of the first part, namely, that it contains a large amount of valuable work. It continues the description of the general diseases, and includes those caused by parasites, by poisons introduced into the body, primary perversions of general nutrition and diseases of the blood. Under "Opium" washing out the stomach is advised only when the dose has been taken into that organ. Surely, it is nowadays recognised that morphia, if in-

jected hypodermically, is rapidly excreted by the stomach. In directing that the patient should be kept walking to and fro, it would be well to point out that this plan of treatment has not unfrequently killed the patient by sheer exhaustion. The danger of relapse in these cases is very properly insisted upon, but no mention is made of the necessity of emptying the bladder by means of a catheter. On p. 66 we notice "morphia" and "morphine" on the same page. Under phosphorus we find no mention of Stockman's classical work on "phossy jaw." It is correctly stated that codeia has no advantage over morphia in the treatment of diabetes mellitus, but it might be added that codeia has the great disadvantage, especially in hospital practice, of costing more than twice as much as morphia. Most of the articles contain good matter well arranged, although at times the information is of a somewhat elementary nature. So far as our criticisms are concerned they mainly deal with minor points of omission. For instance, no mention is made of the value either of belladonna or ergot in diabetes mellitus. Under hæmophilia it is surprising to note that a systematic manual of this importance does not mention the name of Dr. Wickham Legg, in spite of the fact that his treatise on the malady published in 1872 was regarded as the standard work on the subject. Even as recently as 1898 he contributed an article on the subject to Clifford Allbutt's *System of Medicine*. The articles on diseases of the blood have been entrusted to a writer who is now a Commissioner of Lunacy. The subject, however, has been ably dealt with, and is illustrated with some extremely beautiful coloured plates, and we are glad to note that the writer does not think it necessary to call a red corpuscle an erythrocyte. No mention is made of the Tallerman superheated air treatment in the otherwise extremely able article upon gout. Under rheumatoid arthritis the topical application of dry air heated to 250° F. or 300° F. is mentioned only to be dismissed curtly by Dr. Dawson with the remark that it is doubtful if it has any curative action. Dr. Allchin, who writes the article on chronic rheumatism, says that dry heat will "sometimes effect most satisfactory results." It seems almost incredible that such an attitude should be taken in a modern manual of medicine with regard to so powerful a therapeutic agency in gouty, rheumatic, and allied conditions as that afforded by the Tallerman superheated air-treatment. On the whole the editor's laborious and responsible task has been well and conscientiously performed. Both he and the publishers may be congratulated upon the general excellence of their production, which should be in the hands of all practising physicians.

#### HUNTER'S ORAL SEPSIS. (a)

THIS is the reprint of an article which appeared in *The Practitioner* of December, 1900, and is published in this separate form "in the hope that it may serve to draw additional attention to a source of disease extremely prevalent and most egregiously overlooked."

In the first place attention is directed to the local effects of oral sepsis as affecting the mouth, jaws, tonsils, and pharynx; and then Dr. Hunter points out that infective disease of the mouth is not the "mere question of the presence of an organism, however pathogenic, but a question of dose and resistance." This is the keynote of the book. According to the bacteriological investigations of Miller, Galippe, and Vignal, Jung, and more recently Professor Arkov of Budapest, it is shown that the bacillus gangrenæ pulpæ was present in 95·3 per cent. of cases of dental caries; the staphylococcus pyogenes aureus in 34·8 per cent., and the streptococcus pyogenes in 23·2 per cent., &c., &c.

Now, without doubt, as Dr. Hunter points out, if such pus organisms are constantly being swallowed there must result what he terms a septic gastritis. And this in addition to the indigestion set up by the swallowing of imperfectly masticated food (owing to the bad teeth).

(a) "The Thermal Waters of Bath." By Gilbert A. Bannatyne, M.D., M.R.C.P., Honorary Physician to the Royal Mineral Water Hospital, Bath. Bristol: John Wright and Co. London: Simpkin, Marshall, Hamilton, Kent, and Co., Ltd.

(b) "Clinical Lectures on the Various Forms of Intra-Abdominal Suppuration." By A. H. Tubby, F.R.C.S. Pp. 91. Medical Publishing Company, Limited.

(c) "A Manual of Medicine." By W. Allchin, M.D. Lond., F.R.C.P., Senior Physician and Lecturer on Clinical Medicine, Westminster Hospital, &c., &c. Part II. London: Macmillan and Co. 1900. Price 7s. 6d.

(a) "Oral Sepsis as a Cause of Disease." By William Hunter, M.D., F.R.C.P. London, Paris, New York, and Melbourne: Cassell and Company, Limited. 1901. Pp. iv. and 30.

Particulars are given of six cases, all suffering from three main symptoms, viz., salivation, gastric discomfort, gastric catarrh, all of which were cured when either the ill-fitting septic plates were regularly and properly cleaned or perhaps a few old stumps removed.

Regarding the more general effects— toxic effects—of oral sepsis Dr. Hunter tabulates five varieties, viz., fever, septic rashes, purpuric hæmorrhages and bleeding from the gums, profound septicæmia, and toxic neuritis.

Though Dr. Hunter brings forward some seven cases in support of his view that such conditions, as are mentioned above, result from the constant swallowing of pus organisms due to oral sepsis, still the present reviewer would advance the opinion that a much larger number of cases must pass under observation before oral sepsis is shown to be the definite and absolute cause of such conditions. Undoubtedly, Dr. Hunter has done well in putting prominently before the busy general practitioner a possible cause of many obscure gastric disturbances, which is as easily observed as it is generally overlooked.

To the dental profession the book should be of great interest and sound a loud note of warning. For, as Dr. Hunter points out, patients suffering from oral sepsis, who visit their dentist on the urgent entreaties of their physician, often are sent back to the latter in as bad a state as when they went away.

### Obituary.

#### SURGEON-GENERAL CHARLES RICHARD FRANCIS.

WE regret to have to announce the death of an old friend of the MEDICAL PRESS AND CIRCULAR in the person of Surgeon-General Charles Richard Francis, of the Indian Army (retired), who died at his residence, 41, Spencer Park, S.W., in his eighty-first year. Between 1844 and 1875 the deceased officer filled numerous civil and military appointments in India, having at one time occupied the position of Principal and Professor of Medicine at the Medical College at Calcutta, and Physician to the College Hospital. He was also Examiner in Medicine and Obstetrics to the University of Calcutta. Towards the close of his Indian career he held successively the posts of Secretary to the Surgeon-General, Deputy Surgeon-General, and officiating Surgeon-General with the Government of India. In 1853 he was appointed by the Government to investigate, in conjunction with Dr. Frank Pearson, the nature of the mahamurree, which was raging as an epidemic in the hill districts of Kumaon and Gorkhwal. Drs. Francis and Pearson succeeded in demonstrating the identity of this disease with "bubonic plague," and their investigations proved the basis of a valuable report thereon. Dr. Francis devoted much time and energy to the study of snake and snake poison, with the view of discovering an antidote. He was a prolific writer, and was at one time editor of the *Indian Medical Gazette*.

### Medical News.

#### Prosecution of a Medical Man under the Sale of Food and Drugs Acts.

In the Dublin Police Court, on August 9th, before Mr. Wall, K.C.; Mr. J. C. McWalter, L.R.C.S.I., M.P.S.I., trading as J. Leonard and Co., pharmacists, was summoned under the Sale of Food and Drugs Acts for having, on June 28th last, sold to Inspector Rowsome, a Corporation official, a quantity of spirit of nitrous ether which was not of the nature, substance, and quality of the article demanded. The quantity purchased was six ounces. Sir Charles Cameron, City Chemist, certified that the article contained only 0.4 per cent. of ethyl nitrite, whereas it should have contained at least 1.75 per cent. Mr. A. F. Blood, K.C., appeared for the defence. Inspector Rowsome proved the pur-

chase of the drug, and Sir Charles Cameron's certificate was submitted. Mr. Blood drew attention to the fact that in the bottle in which the Corporation specimen of the drug was contained there was only a small quantity of the liquid left, and he submitted that so small a quantity could not be analysed as required by the Act of Parliament. Any deterioration which had taken place occurred after the drug left defendant's branch establishment at Great Britain Street, where it had been procured. Dr. Ashe deposed that the compound in question was of a very unstable nature, and should be secured in a coloured and stoppered bottle. It was really a gas dissolved in spirit, and the bottle in which the specimen now was contained was a most improper receptacle therefor. The magistrate was understood to say that anyone who had to do with whisky knew the importance of keeping it in stoppered bottles. The connection was not apparent, but the several scientific experts present assented to the proposition. Professor C. R. C. Tichborne, M.P.S.I., gave evidence that the spirit of nitrous ether was very volatile and was extremely subject to the action of light and air. He did not consider that the sample produced was in a proper bottle. It was agreed eventually that the liquid in the bottle should be sent to Somerset House for analysis, and the case was adjourned pending the result.

#### Harmful Headache Powders.

AT the Ulverston County Court on Aug. 18th, Jeannie and Willis Shillitoe sued W. B. Hird, a grocer, for £50 damages for a fortnight's illness suffered by the female plaintiff after taking one of Proctor's headache powders sold by the defendant. The medical evidence was very conflicting. One medical man stated that the powders contained 6½ to 7½ grains of antipyrine, and the British Pharmacopœia prescribed the ordinary dose as from 1 to 3 grains. On the other hand, Dr. Anderson asserted that in most headache cases a dose of 4 to 14 grains could be given safely. His Honour held that the negligent sale of a drug had been proved, and gave judgment for plaintiffs for £21.

#### The Manchester Medical Guild.

THE following resolutions were unanimously passed at the last meeting of the Medical Guild, Manchester, on July 26th, as follows:— 1. That in the opinion of the Medical Guild, seeing that vaccination is made compulsory in the interest of public health, the parent or guardian of a child should have the right to select any registered medical practitioner, who is willing to do so, to perform the vaccination, and that the cost of the same should be defrayed by the State at a fixed rate. 2. That, in the event of the foregoing resolution being passed, the Council be requested to consider what steps can be taken to influence future legislation on the subject.

### Pass Lists.

#### Army Medical School, Netley.

SURGEONS on probation successful at both the London and Netley Examinations. Prizes are awarded for marks gained in the special subjects taught at the Army Medical School. The final positions are determined by the marks gained in London added to those gained at Netley, and the combined numbers are shown:—

F. W. Lambelle ...	5,289	M. C. Beatty ...	3,947
L. J. S. Cahill ...	4,703	J. R. Welland ...	3,686
W. C. Stevenson* ...	4,165	H. W. Long ...	3,385

\* Gained De Chaumont Prize in Hygiene.

List of surgeons on probation recommended for commissions in the Royal Army Medical Corps at the close of the 82nd session. These gentlemen were nominated to the Army Medical School:—

T. F. Ritchie ...	2,105	H. Rogers ...	1,688
A. W. Sampey ...	1,786	W. J. S. Harvey ...	1,606
T. J. Potter ...	1,778	W. Davis ...	1,570
A. J. Williamson ...	1,751	J. C. Hastings ...	1,426
E. V. Ayles ...	1,681	D. O'Donoghue ...	1,399

## Notices to Correspondents, Short Letters, &c.

✎ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the publisher or printer before the type has been distributed. This should be done when returning corrected proofs.

ORIGINAL ARTICLES or LETTERS intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication, but as evidence of identity.

READING CASES.—Cloth board cases, gilt lettered, containing twenty-six strings for holding the numbers of THE MEDICAL PRESS AND CIRCULARS, may now be had at the office of this journal, price 2s. 6d. These cases will be found very useful to keep each weekly number intact, clean, and flat after it has passed through the post.

VICTOR.—The quotation is from Addison, and runs as follows:—"A wealthy physician who can help a poor man and will not without a fee has a less sense of humanity than a poor man who kills a rich man to supply his necessities."

R.A.M.C.—The time is past, let us hope, when an Army medical officer is "to be seen and not heard." We shall be very pleased to consider any carefully thought out suggestions on the reform of the Service, although frankly it appears to us that the subject has been well threshed out already.

M. E.—If the skiagram was made at your request, and paid for by you, the copyright, we imagine, is yours. In any event it would be a gross breach of commercial etiquette for the operator to make public use thereof without previously obtaining your consent.

J. H. C. (Salford).—Many thanks for letter. We should like to see the matter taken up as you suggest, and we think the case merits the attention of the Irish Medical Association.

Dr. H. S. C.—The decision of the arbitrator has only just been given. It is in effect that the past arrangement between the County Council and the borough for providing accommodation for pauper lunatics should cease, and that a new arrangement be made under section 244 of the Lunacy Act, 1890.

Dr. J. E. W. (Vienna).—The gentleman addressed is away on holiday, but returns this week, when your communication will receive attention.

Dr. J. C. T.—Communication is marked for next number; proof will be sent you in due course.

### JURYMEN AND MURDERS.

D.C.L. (Brighton).—1. The number of jurymen at a coroner's inquest may be anything between twelve and twenty-three. Anyone should necessarily arise, may be summoned from the street to act as jurymen. 2. Yes. The late Dr. Bond was engaged professionally for many years in nearly all the great murder trials. He owed his first appearance in criminal work to his post as Surgeon to the Detective Department of the Metropolitan Police. His first notable achievement was the discovery in the brain of the woman murdered by Wainwright of three bullets that had been overlooked in a previous post-mortem. Among other medico-legal cases he was prominently engaged in the Camp murder, the mysterious Jack the Ripper murders, and also the Lefroy, Lamson, and Neil Cream cases. His uncle acted as a surgeon to the London, Brighton, and South Coast Railway, and under him Dr. Bond is said to have acquired his first experiences of surgery by attending a railway accident at Bishopstoke.

F. G. WILLIAMSON (Cumberland).—We have ascertained that the writer of the medical notes to correspondents in the Sunday newspaper you mention is a qualified medical man, but the only body likely to take up the matter is the Medical Defence Union. The General Medical Council would, probably, take no cognisance of an offence of this kind unless formally brought to its notice.

### Appointments.

ARTHUR, RICHARD, M.D. Edin., Honorary Assistant Surgeon, to the Ear and Throat Department of the Sydney Hospital.  
BARNES, E. W., L.K.Q.C.P.Irel., L.F.P.S.Glasg., District Medical Officer to the Liverpool Union, vice Dr. Caldwell, resigned.  
COLLUM, ROWLAND W., M.R.C.S., L.B.C.P., Assistant Anaesthetist to the Hospital for Sick Children, Great Ormond Street, W.C.  
COULTER, B. J., M.B., F.R.C.S.Irel., Ophthalmic Surgeon to the Newport and Monmouthshire Hospital, vice B. W. Gowring, M.D., resigned.  
CURTIS, H. J., B.S.Lond., F.R.C.S.Eng., Assistant Surgeon to the Royal Hospital for Children and Women, Waterloo Bridge Road.  
DIX, E. H., M.B., B.S.Durh., Junior House Physician to the Royal Infirmary, Newcastle-on-Tyne.  
GRESSWELL, D. A., M.D.Oxon., Permanent Head of the Department of Public Health, Victoria.  
HESLOP, J. W., M.B., B.S.Durh., House Surgeon to the Royal Infirmary, Newcastle-on-Tyne.

ORMEROD, HENRY LAWRENCE, M.D., B.Ch. R.U.I., L.R.C.P.Lond., M.R.C.S., Medical Officer to the Shirehampton Isolation Hospital.  
PORTER, A. E., M.D., D.P.H.Cantab., Assistant Medical Officer of Health for the City of Leeds.  
ROE, B. W. E., L.R.C.P., L.R.C.S.Irel., Medical Officer for No. 2 District of the Ongar Union.

### Vacancies.

Belmullet Union.—Medical Officer. Salary £130 per annum, and £10 per year as Medical Officer of Health, together with registration and vaccination fees. Immediate application, accompanied by diplomas and testimonials, to E. N. Flynn, Clerk of Union. (See Advt.)  
Birmingham Workhouse Infirmary.—Assistant Resident Medical Officer. Salary £100 per annum, with apartments, rations, coals gas, laundry, and attendance.  
Bradford Children's Hospital. House Surgeon. Salary £100, with board, residence, and washing.  
Bradford Royal Infirmary.—Dispensary Surgeon, unmarried. Salary £100 per annum, with board and residence. Also Junior House Surgeon, unmarried. Salary £50 per annum, with board and residence.  
County Asylum, Lancaster.—Assistant Medical Officer, unmarried. Salary £150, increasing to £200, with apartments, board, washing, and attendance.  
Eastern Counties' Asylum for Idiots, Imbeciles, and the Feeble Minded, Colchester.—Resident Medical Attendant, unmarried. Salary £100 per annum, with furnished apartments, board, and washing.  
East Riding of Yorkshire.—County Medical Officer of Health. Salary at rate of £400 per annum, rising to £500 per annum, with allowances. (See Advt.)  
Great Northern Central Hospital, London.—Vacancies for House Physician. Salary £60 per annum; Junior House Physician, Salary £30. Board, residence and washing provided in each case. Also Junior House Surgeon, Salary £30, with board, residence, and washing; and a non-resident Assistant House Surgeon, with Salary at rate of £30 per annum, and partial board. Full particulars of these vacancies will be found in our advertisement columns.  
Johannesburg.—Medical Officer of Health. Salary £1500 per annum.  
Northampton General Infirmary.—House Physician, unmarried. Salary £100 per annum, with apartments, board, attendance, and washing.  
Salop Infirmary, Shrewsbury.—House Surgeon. Salary £100 per annum, with board, washing, and residence.  
Scarborough, Borough of.—Medical Officer of Health. Salary £325 per annum, rising to £375 per annum.  
Stamford, Rutland, and General Infirmary.—House Surgeon. Salary £100 per annum, with board, lodging, and washing.  
Suffolk General Hospital, Bury St. Edmunds.—House Surgeon. Salary £100, with board, lodging, and washing.  
Township of Manchester Workhouse, Crumppall.—Junior Resident Assistant Medical Officer. Salary £110 per annum, with apartments, fire, light, washing, and attendance.  
University of Glasgow.—Examiner for Degrees in Medicine and Science, with special reference to Physics. Salary £30.  
Victoria Hospital, Folkestone.—House Surgeon. Salary £100 per annum, with board, residence, and laundry.

### Births.

GODSON.—On August 9th, at Linden House Cheshire, the wife of John H. Godson, M.R., B.S.Camb., of a daughter.  
GREEN.—On August 17th, at 2, West Hill, Sydenham, the wife of H. Melville Green, M.D., of a daughter.  
HAWKINS.—On August 5th, at London Street, Reading, the wife of Francis Henry Hawkins, M.D.Edin., M.R.C.P.Lond., of a daughter.  
NEWBOLT.—On August 13th, at 42, Catherine Street, Liverpool, the wife of George Palmerston Newbolt, M.B., F.R.C.S., of a son.  
SCOTT.—On August 13th, at Hurstpierpoint, Sussex, the wife of William John Scott, L.R.C.P.I., of a son.  
WAGHORN.—On August 19th, at 8, Glenluce Road, Blackheath, the wife of J. W. Waghorn, L.R.C.P., R.N., of a daughter.

### Marriages.

HATCH—PACKE.—On August 14th, at St. Andrew's Church, Wilmcote, Stratford-on-Avon, Herbert Lincoln Hatch, M.B., of Johannesburg, to Maud Elizabeth, elder daughter of the late Charles Lewis Packe, Esq., of Harefield, Middlesex, and of Mrs. Jucefix, of Wilmcote Vicarage.

### Deaths.

BELL.—On August 16th, at 1A, Cavendish Road, St. John's Wood, London, Alfred James Bell, M.R.C.S.Eng., L.R.C.P., aged 55.  
BOULTER.—On August 7th, at Farquhar Road, Upper Norwood, Samuel John Boulter, M.R.C.S., L.S.A., aged 83 years.  
BROWN.—On August 16th, at Clarence Road, Southsea, Fleet-Surgeon William Brown, R.N., age 155.  
FRANCIS.—On August 10th, at Spencer Park, in his 81st year, Charles Richard Francis, M.B.Lond.  
SWETE.—On August 9th, at Castle Hill, Fishguard, Pembrokeshire, Horace Lawton Swete, L.R.C.P.Lond., J.P., eldest surviving son of Horace Swete, M.D., of Weston-super-Mare and Dunmarklyn, co. Cork.

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## Original Communications.

### SOME OBSERVATIONS ON THE ÆTIOLOGY AND PROPHYLAXIS OF ENTERIC FEVER IN SOUTH AFRICA,

MORE ESPECIALLY THE COLONIES OF  
NATAL AND THE TRANSVAAL.

By E. BLAKE-KNOX, B.A., M.D., B.Ch., B.A.O.  
(Univ. Dubl.), L.M.,

Formerly Asst. to Lecturer in Pathology and Bacteriology, Trinity  
College, Dublin; Lieutenant, Royal Army Medical Corps.

Of the prevailing diseases met with during my recent tour of active service in South Africa, by far the most prominent in its severity and medical importance has been typhoid or enteric fever. Statements as regards the ætiology of this fever and its prevalence in respect to South Africa, more especially the colonies of Natal and the Transvaal before the commencement of hostilities which I have had access to, do not in all cases hold true when contrasted with the conditions under which these countries have been placed while in a state of war.

Before the war enteric was said to be very prevalent, especially in the high lands. It was epidemic during the Zulu war, at Utrecht, and after the last Boer war at Newcastle, Pietermaritzburg, and Ladysmith, while garrison stations have always suffered year after year. February, March, and April are said to be the months of greatest prevalence; those of November, December, and January ranking next. The civil populations and natives were said to suffer severely, so that towns and kraals were to be regarded as suspicious foci.

During this war, previous to embarkation, each officer of the Royal Army Medical Corps was furnished with a memorandum prepared with elaborate trouble by the Medical Department of the War Office, and having reference to the probable diseases to be met with in South Africa, and suggestions as to the prophylactic and other measures most suitable to be observed. In this memorandum it was pointed out that the streams and rivers were constantly polluted by adjoining habitations and also by the carcasses of dead animals, and that an equally potent cause was the neglect of conservancy arrangements and the constant pollution of soil that is taking place. One of the chief sources of infection in camping grounds being the urine of people who are suffering from, or who have suffered from, enteric fever. It was laid down that the best prophylactic measures for medical officers to follow was to see that in all camps, especially standing camps, an intelligent and daily use of disinfectants be followed, that sanitary supervision of the strictest possible nature should be adopted on the following lines. That in addition to the usual precautions required in connection with water supplies, such as boiling and filtration, the daily use of disinfectants in all latrines, urine tubs, soakage pits, &c.,

becomes essential. For this purpose quicklime was recommended as the best material to be used. It was to be added in the form of freshly prepared milk of lime (one part hydrate of lime to eight parts of water), the quantity to be added to urine tubs, soakage pits, latrines, &c., should be, roughly, in the proportion of one part milk of lime to twenty parts of the contents of buckets, receptacles, pits, &c.

The milk of lime was to be sprinkled freely on the surface of the soil in the neighbourhood of latrines, and wherever surface pollution was likely to take place. Another important point was the protection of food from the contamination of flies or faecal dust. Kitchen refuse was never to be allowed to accumulate, but was to be immediately burnt, and wherever flies appeared to congregate it was to be taken as an indication that refuse or other organic matter was present, and that steps were to be taken to use strong disinfectants to destroy if possible the flies breeding there.

Many other valuable suggestions, which time and space will not allow me to enumerate, were laid down in this memorandum, so that in this particular campaign it was endeavoured to move a step in advance of previous campaigns in the methods of obtaining, above all things, a pure water supply for the troops; the second precaution advised by the Medical Department to the War Office was the provision of a filter suitable for troops on the move. Many of the so-called sterilising filters used in previous campaigns have been next to useless; they get out of order, the candles break, they get coated with mud, they are heavy and difficult to carry about, and generally, as experience has shown (for example, in the Ashantee campaign), they were left at the base as useless. The Medical Department, on careful consideration, recommended the adoption of the Berkfield filter. This filter was tried for the first time at the Salisbury Plain manoeuvres of 1899, and though open to some objections for field service was by far the best filter in the market. This Berkfield filter was designed to filter thirty-four pints in ten minutes, and was sufficiently light to carry with troops. One was to be supplied to every unit of 100 men, and was supposed to be able to be brought into operation whenever a pool or any water which might be a source of water supply during the march was found. It was supposed to filter water at a sufficiently rapid rate to give each man of a unit of 100 men a fair quantity of drinking water within thirty minutes or hour of the halt.

But having the defects common to sterilising filters for troops on the march, it cannot be worked perpetually, the candle gets clogged, and the more clogged it gets the more difficult it is to work, and it was to rest with the men themselves to organise a method of passing this filter from man to man and keeping it cleaned.

The third prophylactic measure I will mention advised by the Medical Department, which, although as yet in its infancy, was that of vaccination of the troops by an anti-typhoid vaccine prepared in the laboratory of Professor Wright at the Army Medical School at Netley.

The principles upon which this anti-typhoid inoculation is based by him are as follows:—First, laboratory experiments have clearly proved that animals inoculated with dead cultures of typhoid bacilli have a greater

power of resisting infection from living typhoid bacilli than animals not inoculated. It may be inferred that this rule will hold good with man from the fact that the anti-typhoid inoculations induce in man precisely the same blood changes which they induce in animals. Secondly, the blood changes which occur in man by anti-typhoid inoculation are precisely the same as occur in him by an actual attack of typhoid fever. The importance of this last fact becomes apparent when it is considered that the insusceptibility against further attack, which supervenes upon an actual attack of typhoid fever, is almost certainly dependent upon the occurrence of the particular blood changes which are here in question. While at Netley I had the opportunity of seeing the preparation of this serum and personal demonstrations on the means of inoculation.

The vaccines are prepared from sterilised typhoid cultures grown either on agar-agar or nutrient broths of various compositions, the strength of each vaccine is ascertained in the laboratory by inoculation on animals, and a small quantity of antiseptic is added to it to provide against all possibility of contamination. It is then put up for use in either sealed glass capsules for one or two vaccinations, or in glass bottles covered with paraffined indiarubber caps, containing enough serum for occasions when a number of inoculations are to be made at once. The vaccine is sterilised in these bottles before it is sent out. Vaccinations against enteric not being compulsory in the Army, it was suggested to the various medical officers to call for volunteers among the officers and men of the units going out to the war; some were inoculated before going out, others on board the transports, and some in South Africa. Lectures were given in which the medical officers explained in as concise and familiar terms as possible the objects and expectations of inoculation. A call was then made for volunteers, their names taken, and inoculation made in batches, a careful record was entered of each man with his age, number, and name of his regiment. While on passage out in H.M.T. *Divaara* I made a number of inoculations chiefly among the officers and men of the Royal Lancaster regiment and 11th Brigade Bearer Company in conjunction with Captain Tyache, R.A.M.C., following the usual methods as laid down by Professor Wright. The men were taken in batches of five, the flank of each being the site chosen for injection, on account of the looseness of the subcutaneous tissue here, and also from the fact that owing to a certain amount of pain and effusion which follows inoculation, it is always better to choose a site which lies on a more or less protected part from friction or joint movement. The skin having been first made surgically clean, the serum was injected from a hypodermic syringe which had been sterilised in oil at a temperature of 140° C.-160° C.

A thick fold of skin is then pinched up between the finger and thumb, and the needle passed down well into the subcutaneous tissues in the centre of this fold, after the necessary amount has been injected the needle being gently withdrawn, the track left by the needle in the skin should be gently squeezed from without inwards. This last proceeding I think most important, as from the fact of the needle being a large one I have several times noticed a reflux of the serum down the track of the needle, either at its withdrawal or even some time after. Such a reflux as this occurring might easily be overlooked and the case registered as inoculated, and such a subject contracting enteric fever some time in the future and perhaps dying would bias the opinion of some people as regards the advantages of inoculation.

The clinical signs and symptoms which result from anti-typhoid vaccination are subject to considerable individual variations, and can be divided into constitutional and local. Of the former, most cases manifest some degree of malaise, and some even faintness or vomiting; some few show definite rigor. This symptom generally comes on from four to six hours after inoculation. Temperature is seldom below 101° F., and may rise to 103° F., but generally subsides within twenty-four hours. The local symptoms are much the same in

all cases—local effusions at the site of inoculation, heat, redness, swelling, pain—but all pass away within forty-eight hours. Most of my cases I did at 10 in the morning; all turned up for their mid-day meal, some feeling a little stiff in the side, about 25 per cent. were absent from their evening meal at 6 p.m., and those who were present were decidedly sore and stiff. The absentees, on going to inspect them, were found lying up in their bunks, their chief complaint being that they were too stiff to get up. Of several hundred cases vaccinated in no case did any suffering occur after forty-eight hours from the time of inoculation. Professor Wright has pointed out in his memorandum issued on the subject of vaccination the importance of the considerable additional protection derived from a repetition of the inoculation at a later date not earlier than eight or ten days from the first injection. This I was unable to carry out owing to more men coming forward for inoculation than was expected. Finally I inoculated myself, and though somewhat sick and sore for nearly forty-eight hours, I was able to continue my routine duties and eat my meals.

Having now briefly discussed the main precautions laid down before the war by the Medical Department, I shall endeavour to add my own personal observations on the fruits borne by the same during the campaign. My observations are limited to the period commencing December, 1899, and terminating February, 1901, and the ground covered may be taken as fairly typical, as I have been in all four colonies. I will first deal with the subject of inoculation. That inoculation has been a success I have no doubt, but this will be a subject that will require lengthy statistical reports which cannot be completed until the termination of hostilities, for many of the cases entered in the army returns as enteric, and many other cases entered as other kinds of fever, will have to be looked into, for it must be remembered that many obscure fever cases have been diagnosed as enteric in persons who have been previously inoculated. And it must be kept in view that Widal's reaction, when obtained in a person who has been previously inoculated, does not in any way confirm the diagnosis of typhoid which may have been arrived at by ordinary clinical methods. And much less does it conclusively prove the correctness of such diagnosis. In view of the difficulty which has often arisen in diagnosing enteric in inoculated people, it must be the reduction of actual typhoid mortality that must be taken and not the reduction of the presumed cases of typhoid itself among inoculated persons. With this view I have always made it a point to carefully examine all enteric cases in hospital which had been previously inoculated. From the evidence I have collected I am of opinion that the following results will be found true in the vast majority of such cases:—

First, that inoculated cases as a rule run a mild course, and such complications as high fever, hæmorrhage, and perforation rarely occur, i.e., that there is a very great increase of bactericidal power in properly inoculated men.

Secondly, that severe cases of enteric occurring among inoculated men will always leave a history of no distress at the time of inoculation, pointing to the likelihood of the vaccine not taking. None of the cases I either inoculated myself or saw inoculated have died from enteric to my knowledge, and none of these cases to my knowledge have been inoculated a second time.

Passing from the subject of inoculation to the water question we come to what is really the crux of the whole question of our heavy mortality lists in South Africa. The water available for drinking in that country, south of the Pretoria-Delagoa line, is distinctly bad, having one ever present ingredient, namely, mud. In the Lydenburg district, north of this line, the water we met with was pure and of a crystalline sparklency, and wholesome where not poisoned, as I have found it on several occasions, with the ferro-cyanide of potassium used in the mines. The water, which had to be used by the Natal Field Force in its twelve months' journey, had to be drawn from sources previously occupied and contaminated by the Boers. It had to be drawn either



from small rivers or pens, the latter being marshy pools, and was always of a dirty brown colour. The amount of mud in this water was always enormous, even when the water was drawn from a river the size of the Tugela. Mud never at any time being a favourable adjunct to the food of man, he not being a sutorial animal, and acting as an irritant to the intestinal tract, produces an acute gastro-intestinal inflammation which always results in diarrhoea. An acute gastro-intestinal inflammation produced by muddy water is accompanied by

1. Catarrh of mucous membrane.
2. Congestion of the vessels.
3. Spasmodic contraction of the muscular coats of the gut.
4. Development of gas in the interior from the decomposing matter in the water.

Catarrh of the mucous membrane is very apt to spread to the orifice of the common bile duct, and may cause a catarrhal jaundice; this accounting for the many cases of jaundice which have occurred. Congestion of the vessels, especially those of the rectum, when associated with diarrhoea, tenesmus, and flatus, often tends to hæmorrhage; this is materially assisted by the conditions under which a soldier is placed while on the march; he procrastinates the act of defæcation until the last minute, as at least two belts and other impedimenta have to be taken off, and this, followed by a hurried evacuation, results in a bloody and mucous stool of very much the same appearance as that found in dysentery. Acute gastro-intestinal inflammation easily tends to become chronic; this is especially manifest and aggravated in troops fed on preserved field rations and biscuit. When the chronic stage is reached the condition of affairs is most grave. From faulty digestive power the patient emaciates and becomes much debilitated, and the condition of the mucous membrane of the intestines is such that a most suitable nidus is presented to the germs of enteric or dysentery should they be present in any further water drunk. Should such a patient become infected and should he not report sick, as is often the case, especially during fighting (for during such times "Tommy" won't report sick unless he is really "very sick"), let us see what happens. The patient defæcates in the nearest donga; in a hot climate the stool rapidly dries, and is either blown about by the wind or washed by the first heavy rain into the nearest water supply, ready to infect the next comer who draws water from it. So these diseases spread.

During the dark days of the three months preceding the relief of Ladysmith, the water question added itself to the numerous difficulties that General Buller and the Natal Field Force had to contend with. Until the Tugela was crossed no available water was fit for drinking at either Chieveley or Frere; it had to be brought by train in specially constructed trucks and carried thence in tanks on ox wagons to the troops and dealt out sparingly.

At Spion Kop it was the lack of any kind of water, in combination with the untenable nature of the position, that led to the evacuation of the hill. Even when the Tugela was reached the water of that river was contaminated by corpses and dead animals, and was of a deep brown colour from the amount of mud it contained. Berkfield filters, or, in fact, any artificial filters were soon found to be useless. They became clogged after a few pints had passed through, and could not be used. Fuel was so scanty that it took the troops all their time to find that necessary for cooking purposes. Fires could not always be lighted owing to the close proximity of the enemy, as any smoke rising above a hill crest was sure to draw shell fire. During the fourteen days preceding the battle of Pieter's Hill the entire army were huddled together in a valley through which the Tugela ran. Putrefied corpses of horses, cattle, and men contaminated every donga leading to the river, as well as the river itself. The Boers had also been camping in this ground for the previous three months. Torrents of rain fell daily, washing all kinds of contamination into the river, which at that time was then our only water supply.

The sewerage and offal of fever-stricken Ladysmith and Intombi Hospital passed by means of the Klip River also into the Tugela.

Such a condition of affairs gave the medical officers of the Natal Field under Colonel Sir Thomas Gallwey their utmost to cope with, in addition to their already heavy work attending the wounded. It had to be done, and it was done, and yet no epidemic of enteric of any proportion occurred.

When Ladysmith was relieved on February 28th, 1900, it was found that the garrison of that unfortunate town had suffered severely from the water question, and had it not been for the prompt sanitary action taken by the medical officers at the commencement of the siege a still greater amount of sickness would have occurred. As it was, 1,700 soldiers contracted enteric out of a force of 12,000, and about 1,800 contracted dysentery. The only source of water supply in Ladysmith was the Klip River, the water of which was of pea-soup consistency, due to the suspension of large quantities of red mud. Major Westcott, R.A.M.C., who acted as special sanitary officer during this period, in his report on the analysis of the water available there, reports that the water from the Klip River, though notoriously suspicious in quality, only contained one grain per gallon of chlorine, indicating an almost entire absence of organic matter, thus contrasting very favourably with that from a crystal stream on which he was called to report near the gorge of Ladysmith, which contained fourteen grains per gallon, and that from a well in Intombi Sprint, which contained twelve grains per gallon, both of which, of course, were unfit for drinking purposes. As, however, the small extent of animal contamination was no indication of the absence of the typhoid poison, the water of the Klip river was sterilised before the drinking by filtration through Berkfield filters. The mud was precipitated by alum, as long as it lasted, but on December 18th all the available alum was used, and another plan of clearing the water previous to filtration was adopted, which proved to be a great improvement on the previous process. Five open hog-heads were sunk in the river bed at different levels, with the result that there was a constant supply at all water levels of perfectly clear water; this was pumped by the fire-engine into tanks on the bank of the river, of a total capacity of 5,000 gallons. Two water-carts made constant journeys to the filters, which by working day and night gave a daily supply of 1,500 gallons, which was ample for drinking purposes. Each unit also drew from the tanks one gallon per head of clear water for drinking purposes. In connection with the influence of water supply on the causation of enteric, Major Westcott noted that when the men in Ladysmith were supplied with filtered water there was a distinct drop in the admissions for dysentery, while those for enteric fever continued to increase.

On the arrival of General Buller's army in Ladysmith it was manifestly impossible from a sanitary point of view to quarter his troops in the town, and he broke his force up into brigades and stationed them within a convenient radius; some were placed on the line of the Tugela, others at Sunday River, Smith's crossing, Acton Homes and Elands Laagte. It was to the last-named place the 5th Division, to which I was attached, was posted.

The water at Elands Laagte being anything but good, and the health of the troops not being as satisfactory as might be wished after their exposure and precarious living for the last few months, I was asked by the General commanding the 11th Brigade to undertake special duties with regard to water supplies and general sanitary work in the camp, and to furnish him with a detailed list of suggestions dealing with these matters. After enumerating many of the points I have mentioned in this paper, I suggested the following remedies:—

1. *Diarrhoea*.—That any soldiers suffering from diarrhoea should in every case report sick as early as possible and come up for immediate medical treatment, as such cases, with proper therapeutic and dietetic treatment, are easily cured in the early stages, whereas the difficulty of curative treatment is greatly increased

should the ailment be allowed to go on untreated, even for a few days. The dietetic treatment consisted in substituting a milk, cornflour, and soup diet, instead of the ordinary meat, bread, and vegetable diet in a standing camp.

2. *Water*.—All water supplies to be daily inspected and marked by distinguishing flags. That three separate and distinct water supplies were to be recognised, water for human drinking and food purposes water for animals and water for washing, that sentries were to be posted over each of these to see that no interchange was to take place between the uses each pool was allotted to. That all water used for human drinking purposes was first to be cleared of mud by either precipitation by alum, ten grains to the gallon, or passed through mechanical strainers; for this purpose I advised that clean empty barrels, of which we had sufficient number, be utilised. One barrel to be sawed in half in such a way as to form two tubs, each tub was to have a foot square cut out of the bottom, and the aperture covered by a number of layers of fine linen or khaki, this tub strainer was then to be placed over another complete barrel which received the strained water, and the water finally drawn off by a tap below came out clear. This water was now to be passed through a Berkfield filter through which it now easily ran, and it was finally to be boiled if possible. Cleansing of water carts and the men's water bottles with permanganate of potash at intervals was also recommended.

3. *Disposal of Refuse*.—Strict orders were to be enforced as to men using only the recognised latrines and urine tubs, and the proper disinfection of the same with chloride of lime. All kitchen refuse, including preserved meat tin cans, were to be deposited in pits dug for the purpose, and to be burnt. All animal refuse was to be removed some distance out of camp before 8 a.m. daily, and to be burnt when dry. All dead animals were to be taken some miles out of camp and buried at least under three feet of soil. As number of dry fœtid carcasses of horses lay about the battle-field of Elands Laagte from General White's engagement in the previous year, the most effectual method of destroying them was found to be burning.

4. *Inoculation*.—Recommendation of inoculation to all, especially young soldiers, with anti-typhoid serum, is advisable. Major-General Wynne did all in his power to assist the medical officers in their sanitary duties. He embodied the suggestions I have enumerated in camp orders, and paid daily visits of inspection to the various camps.

On May 12th I was appointed to Lord Dundonald's cavalry brigade, and with this I remained for the following six months. This brigade consisted chiefly of colonial troops; it comprised "A" Battery Royal Horse Artillery, Strathcona's Horse, South African Light Horse, Thornycroft's Mounted Infantry, Bethune's Mounted Infantry, Stewart's Mounted Infantry. As it will be of interest to contrast the health of these irregular cavalry with the infantry I had been the previous six months with, I will first give an outline of the composition of each of these regiments. "A" Battery, R.H.A., consisted of men who had been for some time in India at Umballa. Most of them had had malaria at some time or other. The South African Light Horse, as well as Thornycroft's and Bethune's Mounted Infantry, were all enlisted in South Africa and comprised men of remarkable wiry physique, but of very variable ages. Although a large proportion of them were Africans either by birth or adoption, many of the men came from other colonies. This was particularly marked in the South African Light Horse, a number of whom were Australians. Stewart's Mounted Infantry consisted of mounted troops drawn from a number of our regular infantry regiments. Strathcona's Horse was a regiment of Canadians of particularly good build and physique. They were all big men and drawn from the north-western districts of Canada.

During General Buller's continuous advance through Northern Natal into the Orange River Colony, and finally through the Eastern Transvaal, Lord Dundonald's Brigade acted as the advance guard of the army and did all the scouting. We were

also responsible for the selection of water supply and camps and the sanitary conditions of the same which was necessary for the preservation of the health of the main army when it came up. Colonel W. B. Allin, R.A.M.C., Principal Medical Officer of the Natal Field Force, is to be congratulated on the results of his labours in this direction, for no camp for the main army was selected without his first making a thorough investigation of its water supply and other hygienic surroundings, this added to the amount of attention paid to the food and blankets of the men, although hampering General Buller with additional transport (he carried 1,503 medical diets with the Natal Field Force after the line was left in the great advance north), such things greatly helped in reduction of sickness in the Natal Field Force; the statistics of which will very favourably contrast with any other field force or any other campaign our troops have been in. I was with the cavalry for more than six months, and was agreeably surprised at the very small amount of sickness in Lord Dundonald's Brigade. At the same time it must be remembered that any comparison between cavalry and infantry in a campaign in the matter of health and admissions to hospital is hardly fair. The mounted man naturally does not suffer so much from fatigue and thirst as does the foot soldier, who madly rushes to drink any water, no matter how muddy, he meets with on the march, stirring up the mud and thus still further polluting the water in his endeavours to fill his water-bottle. The hardened infantry reservist bears a favourable comparison with the infantry recruit in this respect on the march. While the former by experience has learned that he can march easier and perspire least if he keeps from water during a march, and whom you may see at a halt cool and refresh himself by merely rinsing his mouth with water, and not swallowing it; whereas the recruit hugs his water bottle as his most cherished possession, he fills it at every puddle he can get to, and empties it with the same avidity as an infant does its feeding bottle. The result of continuous water drinking to the recruit is much discomfort, heavy sweating, and exhaustion, and these are the men who fall out on a march and fill up the ambulance wagons. From what I have seen I would be almost tempted to take the water bottle away from the recruit on foreign service. Another, and perhaps the best, explanation as to why this Colonial Brigade contrasted so favourably with the infantry was that so many of the men in it, being South Africans, had become inured to the climate and muddy water through long residence in the country, or had been used to country life in some of our colonies. Another explanation might be the fact of mounted men constantly moving from one camp to another.

There is little further of interest to relate on the water question until General Buller advanced north of Lydenburg. Here, while acting as advance Sanitary Officer of the Force, I had reason there to condemn certain water supplies in several places, as they had been poisoned by cyanide of potassium. Lord Roberts had previous to this drawn the attention of the medical officers of his force to this possibility occurring in the advance through the enemy's country. But I am not sure if any water was found poisoned on his side. The tests I employed were the ordinary ones, a ferric salt giving a blue precipitate with ferrocyanide of potassium. The precipitate insoluble in dilute hydrochloric acid and decomposed by a solution of caustic soda; cyanide of potassium also renders water alkaline. The large amount of iron naturally existing in the water of the Lydenburg district made the poisoning of running water extremely difficult. In conclusion I would like to remark, notwithstanding the fact that a sanitary officer has been condemned by Lord Wolseley as a useless encumbrance in time of war, I think the campaign in Natal has clearly proved that, with the co-operation of the general staff and the principal medical officer in the first place in selection of camps, feeding, and clothing, and secondly, what is even more important, the co-operation of regimental commanding officers with their regimental medical officers, has proved the value of the present system. This could no doubt be perfected by the

allotment of one or two medical officers to the staff of the principal medical officer of a field force, which officers would be made responsible for daily sanitary inspection of all standing camps, camping grounds and hospitals, and conduct water analysis, report on food and clothing, and do medical and surgical research work. *They could report direct to the Principal Medical Officer on the spot and assist him, not only in sanitary matters, but be available in times of urgency.*

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THE THERAPEUTIC AND DIAGNOSTIC VALUE OF TUBERCULIN IN HUMAN TUBERCULOSIS. (a)

By G. A. HERON, M.D., F.R.C.P.,

Physician to the City of London Hospital for Diseases of the Chest.

IN the autumn of 1890 there took place in Berlin one of the most remarkable events that mark epochs in the history of medical science. The announcement of a new method of treating tuberculosis by the man who shared with Lister and Pasteur the honour of having done most for the advancement of scientific medicine and the consequent lessening of human suffering. With much enthusiasm, and with high hopes of its future usefulness, tuberculin was received in the autumn of 1890. Before the end of the following spring the remedy had to a very great extent fallen into disuse, and was damned as loudly as it had ever been welcomed. The outcry against the use of tuberculin—for it was nothing less than this—had for its chief cause the condemnation of its use by another distinguished German, Virchow. The patriarch of present day pathologists said that, in his opinion, the use of tuberculin was fraught with danger to the patient. His reason for making this statement was that he had seen in the bodies of consumptives, who in life had been treated with the old tuberculin, evidence which convinced him that the drug caused destruction of the tissues around tuberculous centres, and so set free the bacillus to do its work upon healthy tissues. Virchow maintained that, had the remedy not been used, the bacillus might have rested, harmless, encapsuled, as we know it often is, by tissues that have undergone an indurative process, and become fibrous. Now this statement of his views by a man so justly famous as Virchow at once attracted attention. There is, I think, no doubt that this expression of opinion greatly tended to deter men from using tuberculin, and to prejudice the medical profession everywhere against its use. And so tuberculin was both made and unmade in Germany!

Of Virchow's objections to the employment of tuberculin I can only say that, in my hospital experience of its action, there has been observed no evidence of resulting spread of disease to seemingly healthy organs, or to neighbouring tissues. The average stay in hospital of the first thirty-five cases treated with old tuberculin by me extended to sixty one days. There was, therefore, sufficient time in which to observe whether or not, in these cases, there was to be obtained clinical evidence in support of Virchow's views. In no case was this evidence found,

and it was often searched for by other physicians besides those officially present in the wards.

It may be worth while to refer in this connection to a case treated by me with the new tuberculin in hospital, and selected for that treatment because the patient was certainly slowly dying of extensive and advanced tuberculosis of both lungs. Dr. Perkins, who is one of the honorary secretaries of this section of the Congress, and was then pathologist to the City of London Hospital, performed the post-mortem examination. He made special search for the presence in the viscera of centres of probable fresh tuberculous infection, but found none. This patient received twenty-six injections of new tuberculin in forty-two days, and the doses ran from  $\frac{1}{100}$  mg. up to 2.5 mg.

Koch had, in the plainest words, and on several occasions, stated that cure of tuberculosis when it affected the lungs could be reasonably looked for, with the help of tuberculin, exclusively in those cases where only a small portion of one lung was infected to a slight extent, and where, of course, there was no evidence of excavation of lung tissue. He also said it would be reasonable to hope for a cure when only a small portion of each lung was diseased, there being no evidence of excavation. Any departure from these types of cases in the direction of increase of the extent of the disease, lessened by so much, in Koch's opinion, the chances of a cure; although even in more advanced cases amelioration of symptoms was, he believed, likely to result from the use of the remedy. Now hospital experience taught me that it is seldom we have there an opportunity of treating these early cases. Therefore it is not common to find in hospital the cases in which cure of the disease can be reasonably expected. So far as my experience of private practice goes, I must say the majority of cases in which I have been asked to advise as to the use of tuberculin have been too far advanced in tuberculosis to permit of high hopes for the best result of the treatment being obtainable. But when in unsuitable cases the use of tuberculin produces no good result, blame should not rest on the remedy.

In my opinion, tuberculin has fallen into discredit: 1. By its frequent use in unsuitable cases. 2. By its administration in too large doses. 3. By neglect of the rule that a dose of it should never be given until the patient's temperature has been normal for the previous twenty-four hours at least. 4. By neglect of the rule that the dose of tuberculin should never be increased, but, on the contrary, should be diminished, when its administration has been followed by a rise of temperature. 5. By the prejudice raised against the remedy, among both doctors and patients, because of the severity of the symptoms which not seldom follow upon its use.

In consequence of a long illness, which, until a fortnight ago, unfitted me for work, I was obliged to relinquish the treatment of the cases I had begun to observe for the purposes of this discussion. Therefore, I am unable to present to you the new work which it was my earnest wish and intention to have submitted to you to-day, and I can deal only with work I have already published. Since the end of 1890, fifty-seven cases have been treated with tuberculin by me at the City of London Hospital for Diseases of the Chest. Fifty-one of these were examples of tuberculosis of the lungs, and six of lupus vulgaris. Of these, five of the lupus cases and twenty-seven of the others were treated with old tuberculin. One case of lupus and twenty-four cases of tuberculosis of the lung were treated with the new tuberculin. At the end of the year 1900 seventeen of the fifty-one cases of lung disease had been lost sight of, practically from the time they left hos-

(a) Abstract of Paper read before the British Congress on Tuberculosis, July, 1901.

pital. Sixteen of the remaining thirty-four were then known to be well, and earning their living. I ask you to bear with me while I touch upon a few of the more important features—as I deem them—of these cases.

Whether consumptives leave a hospital well or ill is a very small matter compared with the answer to the really important question: How many of these people are able to work for their living, and for how long a time did they continue to gain their livelihood? I think the return to useful life of sixteen out of thirty-four cases of tuberculosis of the lungs is not altogether an unsatisfactory result of treatment, and this result was obtained with the help of tuberculin. According to our information at the hospital, ten of these sixteen cases of recovery are known to have remained well and able to work for seven years, three for over three years, and three for nearly two years. Other patients remained able to work for periods varying from a few months to eighteen months, but as they are known to have broken down in health they are not included among these sixteen cases of apparent recovery.

Thirty-two of these fifty-one cases left hospital in 1891. Seven years afterwards—in June, 1898—the information concerning these cases, obtained, for the most part, by the assistant medical staff and nurses of the hospital, was as follows:—Eight of them were dead, ten were well, one relapsed in 1897, having remained well until the autumn of that year, thirteen were lost sight of very soon after they had left hospital.

These patients were all treated by the old tuberculin, and their cases are dealt with in some detail in a paper I contributed to Vol. XIV. of the *Transactions of the Medical Society of London*.

In addition to these thirty-two cases, five cases of lupus vulgaris were then treated by the old tuberculin. These cases all did remarkably well up to a certain point, and then, at longer or at shorter intervals, suffered relapse. In one of the five a relapse did not set in until more than a year after she left hospital, and she would not return for treatment because she said she could not afford to give the time necessary for this purpose.

Some of these cases of lupus vulgaris relapsed while under the influence of tuberculin. It is certain that at this period of the history of tuberculin cases of lupus received unnecessarily high doses of the drug. When relapse took place in, for example, three of these cases, one of them had gained 10 lbs. in weight, and was taking 400 mg. doses of tuberculin; the second was taking 1000 mg. doses, and had gained 10 lbs. in weight; the third had gained 18½ lbs. in weight and was taking doses of 1000 mg. These large doses were given once in a week or a fortnight, and were in these cases not followed by high temperature, nor by other symptoms due to the action of the drug. The patients had been respectively 124, 128, and 135 days in hospital, and had received in that time the first-named 50, and the other two 59 hypodermic injections of old tuberculin. It seems to me difficult to believe that these large doses could have exercised any material influence in the direction of favouring any tendency to relapse. The evils said to result from tuberculin are ascribed to its violent effects upon the tissues, by which, during severe reactions, infection of neighbouring healthy tissue is, according to Virchow's observations, apt to happen. But in these cases there were certainly no reactions when large doses of tuberculin were given, beyond slight redness round the site of the lupoid patches. There were no headaches, no rigors, no high temperatures; and yet, in these circumstances, a relapse did take place, and while the drug was being administered. If the

tubercle bacilli were let loose into the tissues, near the patches of lupus, as a result of severe reactions early in the treatment of these patients, then the drug should, one may reasonably urge, have had ample opportunity to exercise a beneficial influence, owing to the administration of the very large doses, which were not followed by reactions worth noticing. Certainly, in all but one of my lupus cases, tuberculin seemed, after a certain time, to lose its power for good. I confess I have never been able to understand why, in cases which had improved so much, certainly because of treatment by tuberculin, relapse should have occurred while the treatment was in full use.

Since March, 1897, I have used only the new tuberculin. During that year ten cases were so treated in hospital. Two of these cases died. One of them was the man whose case I have already spoken of as having been selected because he was certainly dying. The other eight cases of this year were made up of seven examples of tuberculosis of the lung, and one of lupus vulgaris. They all did very well, and, without exception, left hospital, urging as their sole reason for leaving their fitness for work and their wish to resume work. In December, 1900, three years after treatment, the following was the result of the use of tuberculin in these ten cases:—Two were dead, both of them recognised as being hopeless cases from the first; three were well and supporting themselves by their work; three were lost sight of; one remained well until lately, and returned to hospital a few weeks because of a recurrence of disease.

In 1899, ten patients, five men and five women, were treated in the wards with the new tuberculin. Of these five women two are known to be still in good health. One of the two is a domestic servant, the other is a shorthand writer and typist. Two other women are reported to have broken down in health. The fifth has not been heard of since she left the hospital.

Of the men, one continued well for more than a year after treatment, but appears to have recently had a relapse. He worked as a hawker, and so supported himself. Another seems now to be as well as he was when he left the hospital, and is said to be able to work. The third died November 16th, 1900; the cause of death was not stated to us, but he was carried from his work, and two months afterwards died in his bed. Probably he died from a relapse. The fourth was reported to be very ill a year ago. The fifth is working as a photographer's assistant, but he says he had spitting of blood two months ago.

In Krause's record of his six years' experience of Koch's method of treatment of tuberculosis, he states that of twenty-seven of these cases twelve are well, thirteen improved in health, one *in statu quo*, one is worse. It is, of course, not possible on an occasion like this to go into details at any length; but some authors have more or less emphatically dissented from the outcry raised against the use of tuberculin, e.g., Hansen, of Bergen, Osler, Gatsch, McCall Anderson, Petruschky, Spengler, and others. Those of us who have dissociated ourselves from the outcry against tuberculin, have all expressed the view that in cases of tuberculosis, which fall within the limitation laid down in 1890 by Koch, great benefit to the patient is sure to follow upon a proper use of tuberculin, and very often there is complete disappearance of all symptoms of activity of the disease.

Responsible opinion is unanimous in its recognition of the worse than uselessness of any attempt to treat with tuberculin tuberculosis that is complicated with other inflammation. These mixed in-

fections, as they are called, were not recognised in 1890, and it is only within the last few years that their great importance as complications of tuberculosis, whether of the lungs, of the skin, or of any other tissue, has been clearly apprehended.

Is there good ground for the belief that tuberculin, when properly used, is dangerous in any degree to the patient? From my own experience—and I am responsible for over 2,000 injections of it—I am strongly of the opinion that it is, at least, as safe for the patient as is any other very potent drug.

What, then, is the diagnostic value of tuberculin? That it produces its characteristic reaction wherever tuberculosis is present, there can be no doubt. That it rarely fails to react where there is tuberculosis is so true, that cases in which failure is recorded may safely be neglected. In my own experience of this use of it I have never seen any evil consequences follow its administration. It produces no evil effects in such cases as disease of the larynx, nor in kidney disease with albuminuria and glandular tube-casts, nor in disease of the bladder, nor, so far as I know, in any condition of disease, whether tuberculous or not. As an illustration of the practical usefulness of tuberculin as a test in cases always difficult and often impossible of diagnosis by ordinary methods, I would refer to the excellent work done in this direction by Dr. Eric France, of the London County Asylum, Claybury. His object was to ascertain, with certainty, who among the insane inmates of the asylum had tuberculosis. For this purpose he tested fifty-five of his patients with tuberculin. Characteristic reactions occurred in forty-five of these cases. Thirty-four of them eventually died, and twenty-nine of these thirty-four were submitted to post-mortem examination, with the result that, as Dr. France says, "Active tubercle was found in every case." Ten of the fifty-five patients did not react. Five of those died, and post-mortem, says Dr. France, "No trace of tubercle found in any; five still alive and healthy." Here is his expression of opinion on this matter in his own words: "I injected seventy-five cases with tuberculin, and, personally, I am satisfied, not only with the accuracy of its diagnostic power, but also with its entire harmlessness, both in the tuberculous and in the non-tuberculous."

We know that the best, I had almost said the only, chance of cure of the consumptive is to treat him in the earliest days of his illness. It is a fact, that by no other means can we so early diagnose tuberculosis in men as we can by the help of tuberculin. It is also a fact, that we can do this with safety to the patient. Had tuberculin served no other good purpose than this, it would have deserved our best attention, our high appreciation. I am sure the day is not distant when the discovery of tuberculin will be ranked among the most valued of the many gifts mankind already owes to Robert Koch.

## ALCOHOL AND TUBERCULOSIS.

By JOHN C. THOROWGOOD, M.D.,  
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HAVING read the article by Dr. Kelynaek on the above-named subject, in your issue of August 7th, I should like to make a few remarks on the same.

Speaking from experience at the City of London Hospital for Diseases of the Chest, and elsewhere, my conviction is that the moderate use of alcohol in some form or other is helpful in most cases of chronic pulmonary tuberculosis. I have observed excellent effects in checking diarrhoea to follow on the steady use of a rather rough claret as drink with meat food.

If the food be of a milky or farinaceous character

then brandy or whisky may answer better. As a rule, however, I try and avoid spirit drinking, as when once started the patient is very apt to exceed his proper allowance.

Thus I have known a man who was told to take rum and milk every morning go on increasing his dose of rum till he told me he took half a tumblerful of rum filled up with milk as his regular breakfast. Under this regimen his liver attained a prodigious size and the progress of his disease was much hastened. I only saw him once, but soon learned he had died.

The doctor, when allowing spirits, must fix the patient down to a certain daily allowance with a very strong hand.

When there is hæmoptysis all forms of alcohol should be decidedly withheld.

A good single stout of the Romford Brewery I have found a safe and acceptable drink with many patients. This stout is not heady, is really digestible and nutritious, and does not, like ale, cause cough.

Alcohol appears to conduce to the development of fibroid phthisis, and so may bring about the arrest of the disease in its more serious form. I gather that this was the belief of the late Sir Andrew Clark, for I remember the case of a young chemist whom Sir Andrew was kind enough to see with me, and who was seriously ill with pulmonary tuberculosis.

The case was most unpromising, and the only suggestion made to me was to allow plenty of alcohol in his diet in the somewhat forlorn hope that this might cause the disease to take on the fibroid form, and so life would be prolonged.

Gouty people, whose nutrient tendencies are rather to fibroid change of tissue, seem to me very rarely to suffer from tuberculosis.

In one very well marked case of a man who was rapidly going in the lungs, a sea voyage and most generous living quite arrested the mischief, while true gout took its place, the patient becoming robust and plethoric.

Any one who wishes to get the results of some valuable experience on the effect of alcohol in tuberculosis will do well to peruse the remarks of Dr. Thomas Harris, of Manchester, as they are recorded at page 95 of Dr. Ransome's work on the "Treatment of Phthisis."

The subject is one on which one might enlarge, but I mean this paper to be short and practical. Theoretical objections to alcohol as checking oxidation and so forth I do not consider. I dare say chemists and physiologists could make out serious theoretical objections to the use of tea and coffee, and, used in excess, we know both these beverages may do much harm to stomach and nervous system.

## TONSILLOTOMY RASH. (a)

By WYATT WINGRAVE, M.D.Lond.,  
Physician and Pathologist, Central London Throat and Ear Hospital.

THE occurrence of a skin eruption following operations, often referred to as "surgical rash," is familiar to all of us, but its association with the removal of tonsils and adenoids is perhaps not so widely recognised that a few notes may be of interest.

Recent experience of several instances prompted a reference to my hospital and private records which has revealed thirty-four cases in the course of seven years. Although relatively to the large number of operations this is but a small percentage, I feel from

(a) Paper read at the Twenty-third Annual Congress of the American Laryngological Association, held at New Haven, Conn., 1901.

recent experience that they represent but a portion only of those actually occurring, and that a thorough and systematic inquiry would afford evidence of greater prevalence.

It is the custom at our hospital for all patients who are operated on in the extern department to attend, after a week's interval, for examination; and in several instances the parent has reported that the child was kept at home because it had a rash which was thought to be "something catching." Subsequent investigation, however, in most cases proved its innocence of specificity. In other cases the rash was still visible on the patient and unattended by constitutional symptoms.

Of the thirty-four cases, three which were in-patients proved to be scarlet fever, while one developed diphtheria. The remainder were simple non-specific cases.

*Character of Rash.*—The eruption generally appears on the second or third day, either papular, roseolar, or erythematous in type. It most frequently attacks neck, chest, and abdomen, sometimes extending to face and extremities. The earliest appearance noted is on the day following operation; the latest one is on the sixth day. Its duration is generally two or three days, but may extend to five days. After reaching its maximum intensity, it rapidly disappears without desquamation, but is sometimes associated with intense itching.

It may occur at any age—the youngest was four-months and the oldest twenty-three years.

With regard to sex, excluding the specific cases, twenty were females and ten were males.

As a rule there is but slight constitutional disturbance and the child does not appear to be any the worse. In those cases which I was able personally to investigate the temperature was increased  $1^{\circ}$  to  $2^{\circ}$  F.

Although the incidence of so innocent a complication in our most common operation may not be unfamiliar to many of us, I am not aware of any published references having been made to the subject. It is, however a matter of some importance, since foreknowledge will help our diagnosis and prevent any undue precipitancy in forming the graver estimate of its nature.

The occurrence of scarlet fever in three cases and diphtheria in one has, however, an important practical bearing inasmuch as the removal of actively inflamed tonsils is advocated by many surgeons. (a)

There are distinct advantages in this practice, since the prominence of an inflamed tonsil affords facilities to the guillotine, which disappears on subsidence of the inflammation, and there do not appear to be any serious disadvantages. In the absence of any anæsthetic the operation may certainly be more painful, but it most effectually relieves the temporary angina and the removal is thorough. It may happen that tonsillotomy may be undertaken in the early stage of recognised or unrecognised scarlet fever, diphtheria, or other specific fever, and it is maintained by many eminent specialists that not only is no additional risk involved, but that it is an expedient course to take. (b) This may be so if the tonsils alone are removed, but one may reasonably doubt the expediency when a large crop of adenoids requires removal in addition, since the formation of so extensive a denuded surface is not unattended with risk.

The incidence of a rash upon any solution in continuity of tissue, operative or accidental, is well known and has been well discussed, but there are a few points associated with this particular operation which may throw some light upon its pathology.

Examination of the blood during the week following the operation has, with few exceptions, afforded me evidence of an increase in number of the mononuclear white corpuscles. This leucocytosis, which rarely lasts beyond the tenth day, may be more than coincidental, yet it is hardly surprising after so great a disturbance of lymphoid structures. The removal of tonsils and adenoids affords a very large area for absorption of toxic matter.

The rash may also be interpreted as one of drug intolerance, since most of the cases were taking the usual mixture of sodium salicylate and potassium bromide.

Whatever its pathology may be, the knowledge that a rash not infrequently follows tonsillotomy, and that it is not necessarily specific, may be reassuring to practitioners experiencing the phenomenon for the first time.

Since this note was presented eight further cases have been observed and are included in the numbers here given.

## MULTIPLE PAPILLOMATA OF LARYNX. (a)

By N. C. HARING, M.B. Lond., &c.,

Senior Assistant Physician to the Manchester Hospital for Consumption and Diseases of the Throat.

*Description.*—The growth occurs in pinkish masses, sessile or shortly pedunculated, affecting the anterior portions of the larynx by preference, but in many cases arising from the whole surface. Most serious are the cases where there is much subglottic growth.

*Incidence.*—It forms a large percentage of the growths of the larynx in children up to the age of puberty, but is not common in adults. As pertains in all laryngeal growths the male is more liable than the female.

*Pathology.*—Microscopically the growth is seen to consist of proliferated epithelium with but little fibrous structure, and may closely simulate epithelioma. There is no infiltration of the contiguous parts. The distinction from a malignant growth, which is difficult in a p. m. specimen, may be almost impossible clinically, as one has to demonstrate that the epithelial cells do not extend below the border line between the laryngeal epithelium and connected tissue.

*Ætiology.*—There is usually no history of antecedent chronic laryngeal disease, nor of any family predisposition. It may appear congenitally. There is strong reason to believe that this growth is analogous to warts on the skin, and especially so in its doubtful relations with epithelioma.

*Symptoms.*—The ordinary ones of laryngeal growth, unless pieces of the growth are expelled during cough, the diagnosis can only be made by obtaining a view. In children where ordinary laryngoscopy may be difficult or impossible, I have found the direct view into the larynx, by means of Korstein's or Escat's tongue depressor, with or without an anæsthetic, almost invaluable.

In children there is little fear of malignancy, but in adults it is necessary to note carefully that there is no fixation of any part of the larynx before the possibility of malignancy can be dismissed.

*Treatment.*—Recurrence is almost certain unless the removal is complete. This endolaryngeal treatment is rarely successful.

Brushing the growth over with phenol sulphocarinic acid, which renders the growth friable, is a useful adjunct to endolaryngeal manipulation.

(a) Lennox Browne: Diseases of the Nose and Throat. Fifth Edition. P. 346.

(b) Lennox Browne: Diseases of the Nose and Throat. Fifth Edition. P. 523.

(a) Abstract of Paper read at the Annual Meeting of the British Medical Association, Section of Laryngology, Cheltenham, August, 1901.

ANALYSIS OF CASES.

Age when first seen	Female, H. W. 46	Male, T. Mc. 11	Male, T. M. (Tom). 9	Male, L. B. (Levi). 4	Male, R. N. (Robert). 3	Female, E. M. (Elsie). 2
Duration of symptoms ... ..	Cough; hoarseness about 6 months.	Hoarseness about 2 years; cough.	Hoarseness about 8 months.	Always hoarse; much worse last few months.	Dyspnoea from birth; hoarse a few months.	Hoarse from birth.
Examination ... ..	Ordinary laryngoscopy; spasm easily set up.	Ordinary laryngoscopy, easy.	Ordinary laryngoscopy.	Direct view; ordinary laryngoscopy impossible.	Ordinary laryngoscopy; severe spasm.	Direct view; ordinary laryngoscopy very diff cult.
Treatment, &c. ... ..	Repeated endolaryngeal. Phenol-sulpho ricinate of no use. Pneumonia probably set up by portion of growth inspired into a bronchus.	Endolaryngeal treatment caused proliferation of growth. Phenol-sulpho ricinate no use. Tracheotomy to relieve dyspnoea; 3 months later thyrotomy, which had to be repeated with complete removal of growth; curette; chromic acid.	Endolaryngeal caused irritation. Phenol-sulpho ricinate no use. Tracheotomy; thyrotomy; scissors; curette; chromic acid.	Tracheotomy after 3 months; thyrotomy scissors; curette; chromic acid.	At present under treatment; phenol-sulpho ricinate; and endolaryngeal.	
Result ... ..	Death from sudden laryngeal spasm.	No recurrence 2 years; good voice; can sing with harsh voice.	No recurrence 5 years; fairly good voice.	No recurrence 14 months; voice strong but rough.	Death from laryngeal spasm 2 days before the day fixed for operation.	

Tracheotomy is often necessary to relieve the dyspnoea, and in some cases is sufficient to cause spontaneous evolution of the growth. For radical treatment I have found thyrotomy most satisfactory. In order to preserve the voice it is imperative to divide the thyroid cartilage in the middle line and to avoid cutting the vocal cords. Spraying with extract of suprarenal capsule much reduces the hæmorrhage. The growth is best removed with curved scissors, the places of origin freely curetted and cauterised by the application of solid chromic acid fused on a probe. Absolute thoroughness of removal is necessary, or recurrence is certain.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, August 25th, 1901.

THE FRENCH CONGRESS ON GYNÆCOLOGY.

THE French National Periodical Congress of Gynæcology, Obstetrics, and Pædiatrics will assemble for its third meeting at Nantes on September 28-30, under the general presidency of Dr. Sevestre, of Paris, who will also preside over the Section of Pædiatrics. Dr. Segond, of Paris, will be President of the Section of Gynæcology, and Professor Queirel, of Marseilles, of that of Obstetrics. The questions to be considered in the Section of Gynæcology are: (1) Congenital ante flexion of the uterus as a cause of sterility, and its treatment; (2) causes favouring ectopic gestation; (3) dystocia due to fibroids. In the Section of Obstetrics the programme is: (1) Rupture of the uterus; (2) inversion of the uterus; (3) the fate of prematurely born children; (4) the uncontrollable vomiting of pregnancy; (5) radiographic measurement of the pelvis. In the Section of Pædiatrics the following questions will be discussed: (1) Arthritism in children; (2) meningitic manifestations in the course of digestive infections in childhood; (3) intermittent albuminuria in the child; (4) the defence of childhood (pueri-culture, suckling weaning); (5) conservative methods in the treatment of local tuberculosis; (6) scoliosis, its treatment by kinesitherapy (movement cure).

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, August 24th, 1901.

SPECIAL INSTRUCTION IN BALNEOLOGY.

FOR the benefit and further instruction of physicians a new departure in the teaching of physical therapeutics has been taken in Baden-Baden. The Grand Ducal Government has arranged a ten days' course of lectures and practical demonstrations—at the nominal fee of ten shillings, to defray casual expenses—in the magnificently arranged bathing establishments of that town.

Professor Erb and Professor Rosenbusch, of Heidelberg, will hold introductory lectures, the former on "The Balneological, Physical, and Dietetical Treatment of Nervous Diseases," the latter on "Mineral Springs from a Geological Point of View." Further lectures and practical demonstrations will be held by Dr. Frey (Baden-Baden), "Hydrotherapeutics, their Method and Practical Use"; Dr. Gilbert (Baden-Baden), "Dietetical Treatment and Dietetics in Balneo-therapy"; Dr. Neumann (Baden-Baden), "Hygiene in Bathing Places";

Dr. Obkircher (Baden-Baden), (1) "The Mineral Springs, their Use and Indications, including the New Methods of Inhalation," (2) "Massage, Mechano-therapeutics"; Dr. Boessler (Baden-Baden), "The Chemical Aspect of Mineral Springs, with special reference to Mineral Products, and to the Medical Explanation of the Analysis of Mineral Waters."

The courses will commence on October 14th, and those wishing to take part should send in their names to Dr. Gilbert, Baden-Baden, on or before October 1st.

The *Archiv. f. Gyn.*, H. 102, has an article on

#### PUERPERAL NEURITIS

by Dr. Mattiesen, Leipsic. This disease, according to Möbino, is a paralysis in the region of the median or ulnar nerve, coming on after a normal childbed, in which both sensation and motor power are affected, and especially in the hand most used. The affection commences in childbed sometimes earlier, sometimes later, and after a varying period, always ends in recovery. The lower extremities also may be affected, but to a lesser degree. According to later observation, however, this form of paralysis does not exclusively adhere to this type. Paralysis affecting the larynx and pharynx, the optic nerve, paralysis of the facial and sciatica have also been described.

The aetiology is not known, and treatment in consequence is quite empirical. Prophylaxis also can scarcely be considered, as the gravidity itself is supposed to be the cause. The maintenance of the renal function is considered to be one without influence. Alcohol is to be avoided. The usual anti-neuralgics and anti-rheumatics are useful, and also antipyrine, given, not by the mouth, but subcutaneously. Sodium salicylate acts favourably in the febrile stages, and also on the subjective symptoms. Aspirin may be given to relieve pain. The diaphoresis caused by the salicyl preparation certainly has a beneficial effect in assisting to eliminate the toxin.

The *Munch. Med. Woch.* has an article by Prof. Kehn, Halberstadt, on

#### THE MORTALITY OF OPERATIONS FOR GALL-STONES.

According to the writer the mortality is small so long as the pathological changes are not too extensive and not too far advanced, but it is larger when the affection is complicated by carcinoma or purulent cholangitis. So long as the calculi are limited to the gall-bladder and cystic duct the mortality will not be much above 2 or 3 per cent. If the stones are still in the choledochus the mortality will be higher (4 or 5 per cent.), but so long as there is no diffuse purulent disease operation need not be considered dangerous. The prognosis is, however, just the opposite when the infection reaches high into the bile passages, and when carcinoma is a complication. Simultaneous operation on the stomach and intestines raise the mortality to a possible 20 per cent. if malignant disease is present. If the pancreas is diseased the mortality will depend on the possibility of curing it. The mortality after gall-stone operation will not be further reduced until the cases are brought to the surgeon earlier, and the frequent temporary improvements brought about by treatment in Carlsbad and Neuenahn are a bar to this, as hopes are thereby raised and operative treatment deferred. The experienced operator has a great advantage over the best physician, as the latter rarely has the opportunity for visual and manual instruc-

tion afforded by operation or autopsy. Internal treatment has been but little advanced by advances in knowledge. Now, as before, operations are nearly always performed too late. In the cases seen by the writer the indications for operation have nearly always been empyæma, inflammatory hydrops, frequently recurring colic, chronic closure of the choledochus, adhesive processes, with ectasia of the stomach and pylorus, &c. With these conditions the pathological changes in the bile passages will have been advanced. In the case of malignant complication, also, the opportunity for sufficiently early operation will only be exceptionally afforded to the surgeon, and in a certain proportion of cases neither the physician nor the surgeon will be able to do anything.

The *Klin. Therap. Woch.* has an article on

#### THE MEDICAL TREATMENT OF PERITYPHLITIS,

by Professor Bourget. The professor is opposed to the idea that the onset of perityphlitis is always sudden. On the contrary it may be taken for granted that all affected by the disease have suffered from affections of the bowels and stomach, and that these affections have almost always begun in the stomach, passed on to the bowels, and that the symptoms have lasted months, and even years, before the cæcum or appendix has shown signs of disease. But it sometimes happens that a slight chill to the feet during difficult digestion will set up pain symptoms. The prophylactic treatment of the disease comes, therefore, to the front, and here the first attention must be paid to the diet and avoidance of constipation. The "candidate" for perityphlitis should have a mixed diet, in which flesh meat plays but a small part, whilst vegetables, cooked fruits, and farinaceous foods should form the chief. The fear that fruit seeds would get into the appendix is a groundless one, for the woody seed has a favourable influence on the mucous surface of the intestine, as mucine is formed which facilitates the onward movement of the intestinal contents. The hyperacidity of the stomach must be corrected. This may be done by giving milk gruel or an alkali at the acme of gastric digestion. During intestinal digestion the lower extremities must be kept warm, either by movement or by suitable clothing. The bowels should be opened every day. Saline laxatives are useful - a dessert-spoonful of Carlsbad salts in the morning in warm water. It is better, however, to give a large allowance of cooked fruit with breakfast, and if this is not sufficient one or two castor oil capsules after it. Intestinal irrigation is also useful. Very cold drinks must be avoided even at meals. The author also recommends gymnastic exercises, particularly an auto-massage, consisting in flexing the thigh upon the abdomen when lying on the back, the hands being locked below the knee. This movement should be practiced four times a day, ten to twenty movements each time. On actual onset of symptoms the author advises a treatment based on disinfection of the stomach and duodenum, and washing out of the large intestine. When an attack comes on the patient is put on a liquid diet; 15 to 20 grm. of castor oil are given daily with 1 gr. of salacetyl. If gastric symptoms predominate the stomach is washed out with a 1 per cent. solution of sod. bicarb. When the large intestine is washed out it must be done carefully and so as to avoid pain. Ichthyol is always



used for this in a solution of 4 per thousand. He also uses olive oil containing 1 per cent. menthol thymol in methyl salicylate. After the first two washings the whole fluid is removed; after the third part may be retained. The washings are repeated night and morning. Poultices are applied over the right iliac fossa, and if the swelling is hard and resistant five or six leeches. After the second or third day saline laxatives take the place of the castor oil: sod. bicarb., sod. phosph. anhyd., sod. sulph. anhyd., ana five grms., aq. destill. 1000 grms.; 150 grms. to be given each day in three or four portions.

## Vienna.

August 23rd, 1901.

### THE EFFECT ABROAD OF PROF. KOCH'S LONDON ORATION ON TUBERCULOSIS.

[LETTER FROM J. E. WOLFE, M.D., F.R.C.S.ED., LATE OF GLASGOW.]

WE are here in vacation, nearly all the professors are out of town; some of them will return by the end of this month and others at the beginning of October to resume their clinics. Meantime, the lectures are delivered by their assistants to many English and American students who are working in the various special subjects—eye, ear, throat, skin—in the bacteriological and Pasteur institutes. Some of these assistants are model teachers, who use their large clinical material to the best advantage. These are generally considered as the dog-days in Vienna, but the weather has been pleasant—the thermometer has not risen above 70° to 80° F. in the shade, and the heat is tempered by refreshing showers, making it pleasant for work and outdoor exercise.

Professional opinion here, with regard to Koch's oration at the London Tuberculosis Congress, is partly unfavourable and partly sympathetic. His position is not considered enviable. About twenty years ago he prematurely announced a cure for phthisis by his tuberculin, which Virchow unmercifully proved to aggravate the disease by breaking up local tubercles and disseminating them over the whole system. Veterinary surgeons, nevertheless, have adopted tuberculin as a means of diagnosis in cattle: first, in dairy cows when ailing, or in suspects only, but they have gradually extended the sphere of their operations to the whole bovine race, whether ailing or not. These practices have been carried on without Koch's authority or sanction. Now, after the lapse of so many years, the master pronounces the performances as a flat mistake. This pronouncement has caused great disappointment, especially among his veterinary disciples, and the Professor runs fresh danger, like Actæon, of being torn by his own dogs. In the opinion of some, Koch ought to have first broached the subject at local societies before bringing it up in that great assembly—it was too great a shock to his followers. But he had no alternative; the practices founded upon his teaching have assumed such colossal dimensions, the great interests of mankind are so much involved that he was bound to give his new views the most impressive form. I was thinking of poor Macbeth's moral philosophy:

“— that we but teach

Bloody instructions, which, being taught, return  
To plague the inventor.”

The excitement caused by Koch's oration has served the cause of truth by inducing the German Government to appoint a Commission to examine the whole tuberculosis question, Virchow being one of the commissioners. In his address to the Clinical Society of Berlin Virchow says:—“At that Commission I shall endeavour to establish the difference between pathological and bacteriological tuberculosis. Bacteriologists regard everything as tuberculous in which tuberculous bacilli are found. When a section of a wart is put under the microscope and a bacillus is found they take it for granted that there must be millions behind and call it tuberculous, whilst I call only those things tuberculous which are composed of cells—organisms grown out of the body. Tuberculous bacilli alone do not constitute tuberculosis.” There will be the Koryphæ of scientists at that Commission working together to find a sure basis for therapeutics. Koch's labours are not lost to mankind. Whether the bacillus alone or in conjunction with Virchow's pathological cell or by their discovery of a new ingredient in tuberculosis they are sure to arrive at it at last. Lister commenced his labours with carbolic patty, spray, and faith. He developed his system gradually and patiently until now, when Lord Lister is considered the greatest benefactor of suffering humanity by all nations. Nowadays we are in too great a hurry for immediate cures.

## Budapest.

[FROM DR. ADOLF EEDÖS.]

August 20th, 1901.

At the recent meeting of the Nagyvárad Medical and Pharmacological Society, Dr. Révész, Vilmos, demonstrated a pathological preparation originating from a patient who had suffered from

### SPINAL AFFECTION.

The patient, æt. 36, was admitted to the hospital on August 6th, 1900. He complained that he had previously been very weak, and he was therefore unable to walk. His condition subsequently improved, but at the beginning of 1901 he again became gradually weaker, and since May had been confined to bed, having neither strength nor wish to sit up nor to get up, and in his lumbar region he complained of marked numbness. Along the spinal cord there was slight pain on pressure; tactile sensibility was diminished below the first thoracic vertebra from the level of the nipple, and there was total analgesia involving the lower extremities. He did not feel a pin prick, but after some delay he noticed pressure with a finger. Cutaneous sensation, *i. e.*, tactile sensibility, was wanting over both knees and over the lower third of the thighs. The heat-sense, too, was greatly reduced; he mistook at the outset the sensation of heat and cold, and he noticed more gradually the change from cold to warmth.

On the upper part of the trunk and over the limbs the tactile heat and pain sensations were normal. Knee reflexes were increased; in the muscles were seen fibrillar twitchings. On the lower part of the right leg the muscles became atrophied, and he alleges the malleolar joint has since his childhood been always rigid. The left lower extremity is not atrophied; on both limbs passive movements give rise to spasmodic contractions. There was no disturbance of the functions of the bladder

or rectum. In the course of the later months serious contractions presented themselves in the lower limbs, besides obstinate constipation and bladder symptoms. At the height of the nipple severe zozary pains; on the trochanters were seen the effects of decubitus. Under the whole course of observation no alteration occurred in the thoracic organs, but only a tickling cough, with moderate expectoration of a catarrhal character.

The autopsy showed the following: When the spinal canal was opened, the dura mater was deeply bathed in pus in the region of the fourth and fifth ribs, which passed through the adjacent intervertebral openings into the thoracic cavity, communicating with the latter. The openings were covered with caseous masses, which were already softened and decomposed. The dura mater of the cord was greatly thickened at this place; it was very hyperæmic, and was infiltrated with tuberculous material. The spinal cord, owing to compression, had become flattened, pale, and anæmic, and when cut across the margins of the medulla spinalis turned outwards. The right lung was firmly adherent to the parietal pleura; when separating it a large cavity was seen extending over all the three lobes which communicated through the intervertebral openings with the spinal canal. The anterior surface of the lung was sound, with emphysematous isles; the left lung was found to be quite healthy. On the ground of these conditions the author was justified in supposing that he had to deal with a primary pachymeningitis externa, the cause of which was tuberculous caries of the vertebrae. The myelitis was of secondary occurrence. The pus passing towards the thoracic cavity caused the decomposing process in the right lung.

It is yet a matter of question to decide whether the pachymeningitis externa may be a primary or a secondary disease. In most cases it is a secondary factor, but in the present case he had no doubt that it was of primary occurrence. This is proved by the fact that neither on the admission of the patient to the hospital nor later on did the signs of more severe alterations in the lungs show themselves. The slow process commenced between the narrow walls of the spinal canal, broke through from thence the intervertebral opening, and penetrated first to the thoracic cavity, then into the firmly adherent lungs. Traube also found that in similar cases the primary disease was the pachymeningitis externa, which subsequently extended into the dorsal muscles.

At the time of the patient's admission the diagnosis of Dr. Révész was syringomyelia, on the ground of several symptoms, and even the further progress of the case seemed to strengthen this diagnosis. However, the autopsy failed to authenticate it.

#### SARCOMA OF THE CHOROID.

Dr. Waldmann, Bèla, brought forward a patient whose disease he calls sarcoma choroideæ.

The patient, a man, æt. 24, about eight weeks before noticed that he did not see absolutely with his right eye. On examining the eye Dr. Waldmann found the cornea intact, and also the conjunctiva, but the anterior chamber was deeper than normal. The conjunctiva was injected in one place only. By focal lighting he noticed at one part of the pupil a brownish-red growth, and when the light had been thrown on this spot there

appeared a reflection. The other part of the pupil remained black.

The diseased eye will be enucleated, and after performing this operation Dr. Waldmann will demonstrate the preparation of the pathological eye, and he will again return to this subject.

Dr. Edelmann, Menyhert, read a paper on

#### MELÆNA NEONATORUM.

The patient was a baby, five days old, well built, and seemingly quite healthy. On the day when first seen it vomited after having been suckled, and the vomited milk was mixed with blood. This repeatedly occurred on the same day, and the infant sometimes brought up mere blood, the colour of which was bright red. The faces were dark-coloured from the altered blood in the bowels. On the following day, i.e., on the sixth day of the baby's lifetime, Dr. Edelmann saw symptoms of trismus. From this cause the baby was unable to suckle, although it took food given in a spoon. Death occurred on this day.

In this case sudden bleeding had set in. The blood was derived from the stomach and from the bowel. This bleeding itself was really not a disease, but rather a partial symptom of a disease. The fundamental malady must evidently have been some constitutional disease, as, for instance, syphilis, sepsis, hæmophilia. On the other hand it might also have been a local disease of the stomach or bowel arising either from trauma or from a disturbance of the circulation, for instance, by an ulcer or an erosion. This case may be put down to the first group although he could not elicit any further particulars from the parents of the child.

The interest of this case is in the fact that this disease is relatively very uncommon. Among 700-1,000 parturitions it occurred only in one case (Runge). The bleeding commences a few hours after delivery, most frequently on the second day, but rarely on the fourth or later days (in our case on the fifth day). Fifty to sixty per cent. of cases end fatally, mostly owing to the severe hæmorrhage.

## The Operating Theatres.

### GREAT NORTHERN HOSPITAL.

OPERATION FOR RENAL CALCULI.—Mr. PEYTON BEALE operated on a woman, æt. about 26, whose history was as follows: Ten years previously she had suffered from considerable pain in the left lumbar region and had passed blood in the urine at intervals; the pain had continued with greater or less severity till the present time, but no blood had been passed for at least six years. The patient was extremely spare, and had been admitted under the care of Dr. Beevor, who asked Mr. Beale to see her with a view of determining the nature of the pain. The abdomen was therefore carefully examined, at first without an anæsthetic, and both kidneys were easily felt, in fact every viscous in the abdomen could be quite easily made out, a circumstance which Mr. Beale said must be regarded as quite exceptional. Although each kidney was carefully examined no calculus could be felt, but the left kidney was distinctly larger than the right. On another occasion the abdomen was examined under an anæsthetic, but as the operating theatre was occupied at the time the examination was conducted in the ward, the patient

lying on a bed with a spring mattress. Under these circumstances no calculi could be detected, although the whole outline of the left kidney was easily made out. A few days later a skiagram of the abdomen was taken, and this showed two or three dark patches, each about the size of a filbert, occupying the position of the left kidney; no such dark patches were visible in the region of the right kidney. The patient then went out, but the pain in the left loin still persisted, so she was again admitted, and Mr. Beale determined to cut down upon and explore the left kidney. The patient was brought into the theatre, anaesthetised, and placed on the operating table, the surface of which consists of perforated zinc, *i.e.*, a hard, fairly level surface; upon palpating the left kidney the presence of numerous calculi in it was at once detected beyond all doubt, for they were felt grating against one another without the slightest difficulty. The kidney was then exposed from the loin, and about a dozen hard calculi of all shapes and sizes were easily removed with forceps and scoop. The wound in the kidney was sutured, and the edges of the incision in the loin were brought together, with the exception of a small portion at the lower extremity, about one inch in length, in which a gauze drain was placed. Mr. Beale said that there was a very interesting moral in this case, and that was never to examine the abdomen unless the patient was lying on a hard flat surface. In the present instance he had been obliged to examine the patient in bed on the first two occasions, and he had not been satisfied with the procedure, as he had before met with cases in which renal calculi were only detected on palpating the abdomen when the patient was lying on a hard flat table. The skiagram, he pointed out, was a help in that it showed some abnormality in the region of the left kidney, but the mass so shown was quite indistinct as regards shape. Even after the incision had healed up he expected the patient to return with a sinus at the seat of the wound through which urine would pass. He considered it advisable to remove the remains of the kidney at a subsequent operation, and not at the time the calculi were taken away, as if both were done at once shock was generally very severe, moreover, he thought that it was easier to make sure of removing the whole of the damaged kidney structure at a later date, because as the whole organ shrinks up its extent is more easily determined.

Urine came through the wound for about a week only subsequently to the operation, and the patient was discharged to a convalescent home three weeks later, the wound having quite healed.

**A Lady Dentist Fined.**

A PROSECUTION of some interest to the dental profession has just taken place in London. Two brothers, named Eskell-Paget, converted their business into a limited liability company. One of them withdrew and entered into a covenant not to practice within a certain radius of the original place of business. That condition he broke, and was restrained from carrying on practice by an interim injunction. His wife then carried on the business as the "Eskell-Paget Dental Company," and was summoned for unlawfully using a description implying that she was registered under the Dentists' Act and was qualified to practise dentistry. The magistrate convicted, and inflicted a fine of £5, with £3 3s. costs, with leave to carry the case to a higher court.

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**The Medical Press and Circular.**

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, AUGUST 28, 1901.

**THE DANGERS OF THE STREETS.**

THERE are certain aspects of social life to which the attention of the medical profession is specially drawn. Among them may be mentioned the death-toll of human lives that is annually exacted by vehicular accidents in the streets of the great towns of the United Kingdom. In London alone the number of persons thus killed mounts to the dimensions of a small army. Yet it may be doubted whether the citizens of that vast metropolis, busied as they are with multifarious and absorbing pursuits, realise with anything like exactitude the appalling extent of the mischief that is being done in their highways. The recent death of a prominent official has brought the subject prominently under public notice. In that particular case the cause of death was determined by a coroner's jury to have been purely accidental, but it may be hoped that the wider question thus raised, namely, the dangers of street traffic, may not be allowed to escape without full journalistic discussion. To a great extent the medical profession is concerned, for most of the cases of injury and death resulting from street accidents come under their notice as hospital residents, coroners, or private practitioners. Medical men are in a position to furnish a vast amount of evidence in this important matter, and to set forth in its true proportions a public danger which we venture to regard to no small extent as preventible. Danger to pedestrians may clearly arise from a variety of causes, which may be either due to their own acts, or to those of drivers, or to the instrumentality of pure accident. Personal defects of sight, hearing, or bodily health account for a certain number of street injuries. Recklessness on the part of foot passengers is, in many instances, the main contributing factor. Runaway horses have to be reckoned with, as well as collisions between vehicles and the modern developments of cycles and motor

cars have given rise to their own peculiar dangers. After allowing for the unavoidable margin of accidents, however, there remains a certain proportion due to the incompetence, carelessness, or recklessness of drivers. The police have done their best by a system of registration to regulate those in charge of vehicles, but it may be doubted if offences on the part of licensees are not too readily condoned by restoration of the badge. The root of the evil appears to be a fixed belief on the part of drivers that the road belongs to them, and that all they have to do is to shout to a pedestrian without attempting to stop. In a great majority of vehicle accidents to wayfarers, we believe that the mishap has been brought about by the absurd theory in question. It has been pointed out by a judge that drivers were mistaken in holding that opinion, and that the foot passenger has an equal right to the roadway as well as to the footway. We firmly believe that a vast bettering of the conditions of street traffic could be quickly secured if magistrates and coroners would insist upon the rights of pedestrians in all cases of injury or death from street vehicles brought under their official notice. The police, also, would be able to bring a great deal of pressure upon drivers by way of inducing them to recognise the real law of the road. New dangers are being added to the streets by the development of cycle and motor car and tramway traffic. These facts are being constantly impressed upon medical men, not only on account of accidents, but because they themselves travel upon the King's highway more perhaps than any other section of the community. As regards both cycles and motor cars there can be little doubt that they should be legibly numbered, and that in case of an accident the police should have the power of detaining the owner until his identification has been established. As things go the rider or driver may knock down and maim, or even kill a pedestrian, and, by giving a false name and address evade further responsibility. That state of things amounts to nothing short of a public scandal and its amendment claims early legislative attention. Meanwhile it is a matter of philosophic interest to note how the increase of material prosperity swells the figures of the annual mortality from street accidents. At the same time it is clearly the duty of those responsible for the safety of His Majesty's lieges to see that the loss of life and limb from that source be reduced to the lowest limit of the unavoidable margin.

#### HOSPITAL ABUSE.

THE Forty-third Report of the Board of Superintendence of Dublin Hospitals for the year 1900-1901 has just been issued as a Parliamentary Blue Book. Among many important and interesting details of, and comments on, hospital management generally, one comment seems to us worthy of special attention, inasmuch as it touches upon a matter of extreme practical importance. "Whilst we recognise that under

existing circumstances it is not possible to exclude patients who are not, in a financial sense, legitimate objects of charity, we feel that discrimination should be exercised to ensure that the funds provided for charitable relief should not be spent on persons who are competent to pay for such advantages." The question how to prevent the abuse of hospital charity is one which presses for an answer, which is most difficult to answer, and which at the same time has been most persistently neglected by those whose duty it is to find a suitable answer, viz., hospital boards. The latter bodies are elected to administer the funds of an institution—funds which have been provided by a charitable but careless public for a definite object. In the administration of these funds, the guiding principles should be efficiently to relieve the greatest amount of suffering with the maximum amount of economy that efficiency will permit, and to see that funds collected in the name of charity are expended in the furtherance of charity. All hospital boards, we believe, fully recognise the first of these propositions—a principle important and true if followed in such a manner that the second principle is not at the same time abandoned. Unfortunately, there is a widespread tendency to consider that the first principle stands pre-eminent, that it is the only principle to be followed in the management of a hospital, and that the amount of support which a hospital deserves is in proportion to the number of patients which it relieves. We doubt if a hospital governor ever asks himself or his colleagues whether the long list of many hundreds or thousands of patients relieved in the course of a year represents the same number of necessitous persons treated by charity for the sake of charity, or whether it does not represent a large proportion of charity expended on persons who are not fit recipients of charity. Hospital governors, if taxed with the indiscriminate bestowal of hospital relief, answer that they have opened pay wards into which such patients as can afford to pay are admitted. This is true. but what does it mean? It means that the governors have shifted the responsibility for the bestowal of charity from themselves on to the medical staff. That, in other words, they have said to the patient "You are not an object for charitable assistance, you must pay for your board and lodging, my servants—the medical staff—will then bestow their charity upon you, and prescribe for you, or operate upon you free of charge." And the medical staff, by the rules of the hospital, are compelled to do so. "If they do not," says the Board, "there are other medical men anxious to do so in order to obtain opportunities for gaining experience." We do not want to convey that hospital boards act thus out of mere disregard for the interests of the staff, or out of carelessness in the discharge of their duties. There are few hospital governors who act from either of these motives. The real difficulty in the way of reform is that the governors are, in most cases, men whose time is fully occupied by their private duties, and who have not got the necessary

leisure to devote to the solving of the problem of hospital abuse. Moreover, hospital governors do not, as a class, appreciate the harm which is done by the injudicious bestowal of charity, or the injustice and hardship which such a bestowal inflicts on struggling general practitioners. If they appreciated these points we believe that reform would follow. If a body of men undertake the disposal of funds which have been collected for the relief of the necessitous, it is their direct duty to ascertain that these funds are not used for the relief of the fraudulent. If this end cannot be obtained by indirect means, such as the posting up of notices intimating those who are eligible for the relief afforded by the hospital, the authorisation of the medical staff to refrain from treating patients who are manifestly unsuited for hospital relief, &c., it should be obtained by the direct means of appointing an official to inquire into the circumstances of new patients. This is not the difficult or impossible task that it is usually represented to be. Much can be done to effect reform by the mere process of keeping a book in which the name of the patient, occupation, abode, wages, number of children, and so forth are entered. Such a book will readily show cases which are manifestly subjects for charitable assistance, cases which are manifestly not subjects for charitable assistance, and those which are doubtful. If there is any doubt as to the *status* of a patient, it should be the duty of a special official to make further inquiry. Some patients will undoubtedly tell falsehoods. The number will not be great, and after a few have been detected the number will be still smaller. It may be said that little good would result from such a course. With this opinion we do not agree. At present nothing is done, with the result that the out-patient departments of hospitals are thronged with patients who are unsuited for medical charitable relief, who come there believing, or affecting to believe, that they are entitled to receive it, and who are grossly insulted if they are regarded as recipients of charity. Some solution must be found for the problem of hospital abuse. It is unfair in the extreme, in fact it is immoral, to compel a medical man to perform acts in his public capacity of hospital physician or surgeon which he would not perform in his private capacity - acts which have the effect of depriving of the means of livelihood a possibly necessitous professional brother. And when all circumstances are taken into account, what else do the boards of many hospitals compel their staff to do?

#### NAPHTHALINE POISONING?

IN the first two decades of the Nineteenth Century the name "aromatic compounds" was given to a small group of naturally occurring bodies possessing an aromatic smell and taste. For in those days the physical properties and not the chemical composition guided the nomenclature. It fortunately happened that the name was suitable, for it was found that in addition to certain analogies in their outward properties they were connected by close

chemical ties. In 1832 Liebig and Wohler's paper on the radical of benzoic acid, benzoyl, appeared. The discoveries of other bases soon followed. Berthelot found that if acetylene be heated to a temperature sufficiently high a considerable quantity of benzene is produced. At the same time styrolene, naphthalene, and other hydrocarbons are produced. In 1838 Pelletier and Walker drew attention to the opportunities afforded in preparing trade chemicals for studying new bodies. The by-products of coal-gas yielded naphthalene to Kidd. In 1873 Markownikow and Pylobin found a peculiar group of hydrocarbons in Caucasian petroleum, to which they gave the name of naphthenes. Naphthalene is now obtained almost altogether from crude petroleum, distilling over at a temperature ranging between 180 degs. to 220 degs., from which it crystallises on cooling. It forms colourless, shining, leafy crystals of peculiar odour and burning taste. It dissolves readily in alcohol, ether, chloroform, carbon disulphide, benzene, and fixed and volatile oils. From Cohn's physiological experiments, in 1894, it was considered that the chemical was completely destroyed in the body of dogs, and from the known properties of the drug it was recommended as a vermicide in cases of tape-worm, the dose being twenty grains dissolved in castor oil. In such doses, though often repeated for days, no toxic effects were produced. As an ointment it has been applied in the proportion of one part in eight without even producing a rash; withal even pure naphthalene has been known to produce toxic effects. Rossboch's patient suffered from cyanosis of the lips and cheeks, twitching of the muscles, and black-coloured urine from taking ninety grains; it has also produced strangury, and in at least one case its external use was followed by toxic symptoms. In 1896 it was, however, replaced by naphthalour, of similar chemical composition, though differing greatly in its physical characteristics. It is said to be harmless, and is recommended for all forms of skin diseases, burns, ulcers, and even rheumatic pains. A solution of one of these chemicals was recently used by a Mr. Mallan, of Dublin, in the preparation of a non-poisonous sheep-dip or disinfectant. To show that the compound was not poisonous the deceased was in the habit of drinking some of it. Probably the solution was prepared with methyl alcohol; be that as it may, the unfortunate man drank a quantity of the mixture and died from the effects a short time since, and a coroner's jury found a verdict in accordance with the evidence. There was no necropsy, neither was there any report of the symptoms from which the man suffered, nor any chemical examination of the contents of the stomach. The medical attendant was not to blame for not giving the symptoms, for he was not called in until some fifteen hours had elapsed from the time of swallowing the disinfectant. We incline to the view that the death resulted from the agents used to dissolve the naphthalene, and not from the hydro-carbon itself. And we regret that no post-

mortem was ordered. It would have been interesting to know the condition of the mucous membrane of the alimentary canal and of the urinary apparatus; nor can we understand why an analysis of the contents of the stomach was not made. There is no suspicion of foul play, but the circumstances called for an analysis if only to ascertain the cause of death, a function of the coroner's court that does not a little to safeguard the lives of His Majesty's lieges.

### Notes on Current Topics.

#### Suicide at a Kent County Asylum.

AN inquest was held last week upon the body of an inmate of Barming Asylum, Kent, when it was proved that deceased committed suicide by hanging. The evidence revealed the fact that there was only one attendant in charge of a ward in which were forty-four patients, several of them with suicidal tendencies. The jury expressed an opinion that there should be at least two attendants in the ward. If the state of affairs be as alleged there can be little doubt that a most serious flaw has been disclosed in the administration of the institution in question. Barming Heath Asylum, it may be said, is the larger of the two county asylums of Kent, and has some 1,638 beds. An explanation may be forthcoming for leaving the ward to the care of a single attendant, perhaps on the score of the sudden illness or holiday absence of the staff. In any case, however, provision should be made for emergencies of the kind. It is hardly credible that a county asylum of first magnitude should entrust a ward with "forty-four patients, some of them suicidal," to the care of one man. The Lunacy Commissioners will doubtless hold an exhaustive inquiry into the matter, and may be confidently expected to make any administrative changes that may be necessary to the future safeguarding of the inmates of the Barming Heath Asylum.

#### Verminous Police Cells.

PUBLIC attention has been called to the existence of swarms of parasites in one of the London gaols. In several instances prisoners under remand have obtained bail on the ground that life in the prison was a prolonged torture on account of the vermin with which the cells were infested. There seems to have been no attempt on the part of the gaol officials to contradict the assertion of what constitutes an exceeding grave defect in administration. There can be no excuse for the existence of such a state of affairs, for clearly prison cells can be kept absolutely free of vermin by a proper system of cleanliness in combination with such modern sanitary measures as disinfection and the use of antiseptics. The police exact a high standard in the case of common lodging-houses, and prosecute the owners when vermin are found in the beds. Is it any more difficult to keep a police cell clean than the room of a lodging-house? Of the

two most people would say the chances were greatly in favour of the police cell, with its special construction, its absence of overcrowding, and the official service and capital at command. The fact is that the whole of our prison system wants overhauling from one end to the other. A commission of inquiry should have medical and sanitary experts who would consider every item of environment, food, clothing, exercise, sanitary and personal cleanliness, and all other things from a scientific and humanitarian point of view. The treatment of many persons locked up for the night in police cells demands minute inquiry as to the warmth of cell, coverings of prisoner, food given, and supervision exercised. In some instances the treatment of prisoners locked up from Saturday to Monday in the way of food and exposure is enough to bring on serious physical disease, that is to say, if the report of some of these unfortunate persons on coming to hospital later in the day may be believed.

#### Broken Ribs Overlooked in Hospital.

A CURIOUS incident was revealed at a London inquest last week. A woman slipped on the pavement one night and fell against the handle of a costermonger's barrow. Three days later she applied for medical assistance at the Western General Dispensary, where, it was stated in evidence, she said she had a sore throat and had fallen and injured herself. Her chest, however, was not examined, and next day she went to St. Mary's Hospital, where she was treated by the house surgeon for "laryngitis." Two days after the last visit a private practitioner who was called to deceased found her suffering from pneumonia, the result of five fractured ribs on the left side. She died from syncope on the following day. The jury expressed an opinion that a more careful examination of the patient would have revealed the existence of the fractured ribs. The history of a blow would naturally lead a medical man to examine the chest carefully, but it is only fair to say that the physician at the Dispensary denies that the deceased complained of anything beyond the sore throat. The Coroner, Dr. Danford Thomas, very properly pointed out that in a case of the kind it was essential to bandage the chest. The fact is to be regretted that so serious an injury should have escaped detection by the medical officers of two London medical charities. An occurrence of this nature suggests the need of a revision of administrative methods.

#### The Chigoe.

SIR HENRY COLVILLE tells a tale of a man who was tried before him on the charge of murdering his wife. The prisoner fully admitted his guilt, but explained the killing of the unfortunate woman by stating she was infested with the chigoe. The chigoe, or jigger flea, causes cyst-like formations that can be seen immediately under the skin looking like little fibrous swellings as large as a pea. Their removal must be complete, otherwise an ulcer ensues

which may cause a considerable amount of distress. The native home of the chigoe is South America, but it appears to have been recently introduced into Africa, where, on the West Coast, its wonderful power of multiplying rapidly and travelling far has soon caused its presence to become a matter of comment. Emin Pasha's expedition is further credited with having spread this pest in the continent of Africa, and Sir Henry Colville, describing its progress in Uganda, says that it has maimed whole populations. He foresaw that the jigger would reach the Eastern coast, and it is probable that before long India and Arabia will be invaded by the insect. It is like a small flea in appearance, and curiously enough jumps in the same manner as the flea. It can live and breed in countless numbers in sandy soil. For an hour or two after it has made its way into the skin of the foot no particular irritation is felt, but in a short time excruciating pain is complained of, and the only means of obtaining relief is to promptly extract the intruder, and this must be done most efficaciously and thoroughly. According to Dr. Moffat, an important part of the work of missionaries at the present time consists in imparting to the natives the necessary knowledge of how to effect in a proper manner the removal of the chigoe when it has gained an entrance through the epidermis.

#### Prophylaxis of Blindness.

THE great frequency of ophthalmia neonatorum in Paris, and the frequency with which it is followed by loss of sight of one or both eyes, has latterly engaged the attention of the French Government. The initiative in the matter was taken by Senator Dr. Pedebidon, who brought before the Senate the desirability of asking the Academy of Medicine of Paris to issue instructions to the midwives of the districts of the city to bathe and daily wash the eyes of the newly-born children with a weak solution of permanganate of potassium. The Academy of Medicine recognising that they had no power to enforce compliance with their instructions to the midwives, suggested that the following rules be adopted by the executive:—(1) That there be distributed in each district, with the certificate of birth, a paper giving the causes, symptoms, and dangers of ophthalmia of the newly-born. (2) To ensure that all cases of the disease are duly notified by midwives and doctors. (3) That in all maternity hospitals, there shall be an ophthalmic surgeon, whose duty it shall be to treat the ophthalmia of the newly-born, and to instruct students and midwives in the treatment of the disease. These are admirable suggestions in their way, but is the last one necessary? From what we ourselves have seen of the disease, or perhaps it would be more correct to say from what we have not seen of the disease, it is well proven to our satisfaction that if the precautions and prophylactic treatment laid down by Crede are followed in maternity hospitals there will be no ophthalmia neonatorum. This mode of treatment is as simple as it is efficacious, and

though it may sound well to be able to say that an ophthalmic surgeon is attached to a maternity hospital, still there is more chance of good resulting to a greater number of infants if the regular officers of the hospital make it their business to instruct the charge nurses in their duty in these cases. It will thus be far more thoroughly brought home to the midwives that the prevention of ophthalmia presents no difficulties which they cannot overcome themselves.

#### Pathological Lying and Dreaming.

It is well-known that in hysteria a form of reverie may occur in which the patient imagines the dream in such a vivid and real manner that it henceforth becomes as a matter of fact to her. This morbid state may result in false witness being given, and the term "pathological lying" has been applied to it, Professor Pick, of Prague, has published a curious study of some patients under his care who suffered from day dreams which were so distinctly pathological in their character that the patients themselves recognised their psychiatric significance, and sought medical advice to rid themselves of the domination of a succession of dream pictures. The practical side of the question is shown in the incapacity of these patients to follow their usual vocations in consequence of these day-dreams causing a reaction in various ways, such as talking aloud and gesticulating. This is one of those studies of psychiatry which is liable to excite the ridicule of the thoughtless, but the practical effect of these day-dreams is by no means a laughing matter to the unfortunate sufferer.

#### Medical Advertising under the Pharaohs.

THE King Sahura, who lived 3,500 years before Christ, wished to record his gratitude to his doctor because he had "made his nostrils well," and for that purpose he caused an inscription to be engraved on a tablet in which he wished him long life and happiness. The inscription shows further that the King's physician appreciated the pecuniary benefits of publicity, for at the doctor's own suggestion to his royal master the tablet, or in plain English the advertisement, was placed in a conspicuous position in the waiting room of the regal palace, and it is to be hoped that the worthy practitioner reaped the benefit he deserved, not only for his successful treatment but also for his evident business capacity. Dr. J. Wright in the *Laryngoscope* has written an entertaining article on the subject, which those interested will do well to consult.

#### The Saddleworth System of Medical Relief.

THE Saddleworth Guardians have instituted a system by means of which poor persons can obtain medical relief from any doctor they may desire to consult residing in that neighbourhood. Mr. Colin Campbell, of Saddleworth, has explained the method fully in an article he has written in the organ of the Manchester Medical Guild, the *Medical Guild*

*Quarterly*, under the heading of "Parish Doctor and Outdoor Medical Relief." The method is simplicity itself: The Saddleworth Guardians appoint every registered practitioner in the district who may so wish to be a district medical officer, and in this manner the ordinary contract medical officer's work is avoided, and much unnecessary professional friction is done away with to the advantage alike of patients and practitioners.

#### Pruritus and Lymphadenoma.

THE connection of pruritus with lymphadenoma is not mentioned in the majority of our textbooks on medicine, but the fact that this complication is something more than a mere coincidence has been emphasised by Dr. W. Cottle and Dr. Lee Dickinson, in a communication published in a contemporary describing three cases of pruritus associated with lymphadenoma. The importance of the subject lies in the fact that pruritus in lymphadenoma is of serious prognostic import, and in instances which otherwise do not appear beyond recovery this complication, particularly if accompanied by pigmentation of the skin, is of grave significance. In the cases described the rapid course of the malady fully bore out the prognostic gravity of the pruritus.

#### The Parisian Medical School.

THE falling-off in the number of foreign students attending medical classes in Paris has incited the Municipal Council of the city to take steps to increase the facilities for medical teaching and make the school more attractive. In a series of articles in *L'Eclair*, M. Daussett, President of the Council, shows that during the past twenty years the French schools of medicine are being gradually deserted by foreign students, who now seek instruction in Vienna and Berlin. To stay this stream of foreigners from Berlin and direct them to Paris it is proposed that a "Municipal Institute of Practical Medicine" be established, and supported at the expense of the city. In the institute the student will see the practical application of the theories he has learned in the lecture room. Wards containing about twenty beds each will be utilised for clinical instruction. Each ward will be devoted to a specialty, and be under the care of a specialist who has attained distinction in his branch of medicine. Post-graduate lectures and clinical instruction will be delivered, and it is hoped that many practitioners will avail themselves of a four or six weeks' course every year for the first five years of their professional life. Patients are eligible from all parts of French territory, the desire being to secure specimens of the pathological states that call for careful investigation either from their pathology being little known or from their not being amenable to treatment. We heartily wish the scheme success; the home of Pasteur should be an attraction to students, and our French *confreres* are well advised in teaching Pasteur's theories and demonstrating his teaching in Paris and not relegating the duty to German professors in Berlin.

#### Veratrum Viride in Puerperal Eclampsia.

ANY drug which can be proved to have influence over this serious malady is worthy of note. According to the *Clinical Review* of July, 1901, "at the late meeting of the American Medical Association a number of speakers firmly held to the conviction of the superior efficacy of veratrum viride in puerperal convulsions in comparison with any other drug we possess. While in the convulsion chloroform, of course, would give a rest and relief to be procured in no other manner. Beattie, of Kansas City, recommended that the veratrum be given in ten minim doses, hypodermically, to keep the pulse low. Confield, of Cincinnati, held that in full-blooded persons with a high pulse veratrum could be said to be quite a specific. He advised that from fifteen to sixty minims of Norwood's tincture (according to the patient) be given every fifteen minutes until the pulse reached sixty, where it should be held for several days. In thin anæmic patients with small pulse this drug should not be used. Chloral and morphine were the agents to employ in such instances."

#### The Treatment of Goitre.

AT the last annual meeting of the German Surgical Society Professor Kocher presented the following statistics of his treatment of 1,000 goitres by operation. Of these 929 were cases of simple glandular enlargement, of these four died; twenty-seven were cases of malignant growth, of which six died; twenty cases were of an inflammatory character, of which but two died; twenty-four were cases of exophthalmic goitre, of which two died. These statistics are not alone valuable from their number, the care with which the cases were registered greatly enhances their value: thus we find that of cases of simple growth of the gland, in four cases the growth returned and he had to enucleate the gland. As a rule he found it sufficient in simple enlargements to excise such portions of the gland as were interfering with respiration. His most troublesome cases were those of proptosis; the extirpation was both troublesome and dangerous. Such a brilliant record cannot fail to influence medical opinion. The older methods of blisters, setons, iodine painting, and so forth, were eminently unsatisfactory, and the thyroid extract treatment too often failed to produce the desired effects, and not unfrequently caused undesirable results.

#### The Antiseptic Duel.

A DUEL has lately taken place between the son of a celebrated novelist and a well-known journalist of Paris, in which it is reported that in the course of the encounter the tip of the sword of one of the combatants was observed to touch the ground. The duel was immediately interrupted, and under medical supervision the weapon was carefully and scientifically disinfected. It is gratifying to hear that in consequence of the extreme precautions observed a wound inflicted on one of the parties to the duel is proceeding satisfactorily, and it is probable that in



future any danger that may appertain to modern French duelling will be entirely obviated, to the great satisfaction of all concerned.

#### Able-bodied Soldiers.

THE announcement is made that Lord Kitchener has ordered home a number of the new yeomanry lately sent over sea to the strength of 16,000. The alleged reason is that hundreds of the men are suffering from complaints of physical disabilities that would have been detected by the most cursory medical examination, and many of them are at present in hospital suffering from such diseases as varicocele, heart disease, deafness, lameness, and defective vision. As usual, the blame is thrown on the unfortunate Medical Department, which appears to be the favoured scape-goat of our chivalrous combatants. It must be clear as daylight to the man in the street that an unusual demand for soldiers means a lowering of physical standards. In the piping times of peace it is possible to pick and choose, so that the regular Army is supplied by recruits who, from a bodily point of view, are fittest of the fit. The demand for troops at the Cape is still unslaked, and it is to be hoped that the medical inspectors at home will resist pressure in future and weed out remorselessly all men who are unlikely to withstand the rough-and-tumble of an arduous campaign. Readers of the casualty lists must have noted the number of soldiers who are reported to have succumbed to heart disease and phthisis, which in a certain proportion of cases must have existed previously to their joining the Service. It is a question whether moderate errors of eyesight should be held a disqualification, for in the German and some other Continental armies the class of men labouring under this defect is found useful enough.

#### A Lay Indictment of the General Medical Council.

IN our correspondence columns will be found a communication from a medical man, commenting somewhat severely upon a letter from Colonel le Poer Trench, published in the *Times* of August 20th. The gallant gentleman in question made a frontal attack upon the General Medical Council on the ground that they were created for the protection of the public against unqualified practice, and "not to prevent research and new departures in medicine by qualified practitioners." The Council certainly do not adopt the first proposition, for they decline to prosecute unqualified practitioners, and assert that their function is purely to maintain certain ethical and educational standards among registered and duly qualified medical men. It was in accordance with that interpretation of their administrative powers that they took proceedings against the gentlemen who are mentioned by Colonel Trench, namely, Dr. Irvine, Mr. R. M. Theobald, and Dr. Alabone. Of these three the first, Dr. Irvine, capitulated upon an ethical matter. Mr. Theobald was struck off the *Register* for his connection with a notorious quack, Count Mattei, whose costly remedies

were shown by chemical analysis to have been simply water. Dr. Alabone was proceeded against for treating consumption by methods the worthlessness of which was fully exposed not only in the medical but also in the public Press. His advertised nostrum—"Lachnanthes"—is accepted by the Colonel as a Heaven-sent specific for the cure of consumption, apparently on the strength of a single case which improved between March and May. It may be remarked that any medical man who finds a cure for a disease and endeavours to make money by selling his discovery is running counter to the sound traditions of a noble profession. As to the suppression of quack practice by the Council, it has long been the earnest desire of medical men throughout the kingdom that the Council would undertake that most desirable task, or, if their powers were inadequate, that they would take steps to secure the necessary amending legislation. The second point of the gallant Colonel's indictment—namely, that the Council attempt to prevent research and new departures by qualified practitioners—is too absurd to need discussion in the columns of a medical journal. Legitimate scientific work is outside their control and their action in the case of Theobald and Alabone was directed against pseudo-scientific or quack methods foisted upon the public in ways contrary to professional usage—in other words, both matter and manner were illegitimate.

#### Ordnance Maps and Medical Men.

TO the country practitioner of medicine good local maps are essential, and it is somewhat doubtful whether, as a general rule, he is fully alive to the advantages of the Ordnance Survey maps. The recent change from a four-mile to the inch to a one-mile to the inch scale has greatly enhanced the value of these charts. For the small sum of one shilling a minute key to a district can be obtained, with full details as to villages, roads, canals, streams, houses, and a host of other physical facts. The cost of the map is only one shilling, so that the Government have not hindered the sale of their valuable production by burdening it with an excessive price. For all that, the sale of their publication is of a most meagre description. The inwardness of that curious state of affairs appears to lie in the complicated methods of sale which the Treasury have imposed upon the sale of the Ordnance map. The apparently simple plan of selling through the agency of local post-offices is so muddled and mismanaged that the intending purchaser finds himself faced with a quite unnecessary amount of formality, delay, and additional cost. In spite of these drawbacks, however, provincial medical practitioners may nevertheless be advised to turn to the Ordnance maps for accurate and trustworthy topical charts.

A SERIOUS outbreak of typhoid fever has occurred in Wales at Ebbwvale. Several deaths have resulted. There is no isolation hospital, and medical men are experiencing much difficulty in treating the patient

### Infantile Pneumonia.

ALL physicians dealing with infantile diseases have recognised the difficulty of diagnosing pneumonia in the early years of childhood. We need not repeat for our readers the symptoms of the disease or tell how prone the disease is to be overlooked until too late, or enumerate the diseases for which it may be mistaken; such information is to be found in every good text-book on infantile diseases. Unfortunately students are taught nothing of infantile troubles, and the young practitioner soon finds how insufficient has been his training when he comes to attend children. It is a revelation to him to learn that a child may die of pneumonia without showing any of the symptoms of the disease that he is so familiar with in the adult patient. Even to those familiar with the diseases of early life the recognition of pneumonia is not always easy, and the profession should be grateful to M. Weiss, of Lyons, who describes a sign of the disease in infancy which he has been acquainted with for months past. He finds that there is deficient expansion of the infra-clavicular region of the affected side. From his account the sign is pathognomonic. He has sought for it in other thoracic troubles in vain. It is not to be confounded with the want of expansion of the whole side, which is found in pleurisy and pneumothorax. The pneumonic sign is limited to the infra-clavicular space, and with it is found somewhat less than normal expansion over the site of the lesion. What adds to the value of the sign is the fact that it appears at the beginning of the attack, being well marked before the fifth day. To get the sign clearly it is recommended to strip the little patient and place him on the broad of his back, and when the excitement of the child at being undressed has passed off and the breathing has become normal the difference in the movements on the right and left side of the thorax will be readily seen. Care must, however, be taken not to confound the elevation of the clavicle with pulmonary expansion. The differential diagnosis between meningitis, typhoid fever, and influenza from pneumonia is greatly facilitated by this sign. It is also of much value in recognising the onset of pneumonia in children worn out with the wracking cough of pertussis—a danger not unfrequently unnoticed until the impending death calls attention to it. Considering that every general practitioner of medicine numbers many children among his clients, it is an amazing fact that the medical student is taught nothing of children's diseases, and gets his qualification without being asked one question on the subject.

### Coroners and Post-mortem Examinations.

THE lady resident of a London hospital, Dr. Louisa Garrett Anderson, gave evidence at an inquest held last week upon the body of a child that was brought to the institution dead. She stated that the child was obviously dead, and having ascertained that fact she had not examined the body further. Later it transpired that she expected to have been called upon to make a post-mortem exam-

ination. This drew from the coroner the remark that it was usual for a hospital doctor to examine a body under such circumstances to see whether there were any marks of violence. Where the cause of death was obvious an autopsy was not ordered unless subsequent criminal proceedings were likely to be taken. The matter evidently rests with the discretion of the coroner, who has in turn to depend on the results of the inquiries of his subordinate officer. While the holding of unnecessary inquests is to be deprecated on various grounds, it may be open to question whether post-mortem examinations might not be held more frequently to the public advantage. The consideration of criminal negligence sometimes crops up unexpectedly in the course of an inquest. So far as hospital residents are concerned, they are expected in the majority of cases to perform an autopsy, for which no fee is paid. On the other hand, they receive fees for evidence when a body is brought dead to the hospital, and a further fee for a post-mortem under those circumstances would be a small recompense for much gratuitous work.

### Low-flash Oil.

THE fame of Napoleon Bonaparte as a great military genius was founded on the lives of millions of his fellow-creatures. If one were to seek latter-day parallels in civil life they would probably be found amongst the millionaires who have amassed their money from industrial sources. The brewing trade will at once occur to many readers as an instance of a lucrative trade that brings misery in its train. At the same time it must be admitted that the brewers as a rule furnish good liquor to consumers. It is quite another matter, however, when an inferior and dangerous commodity is supplied to the public simply and solely because of its cheapness. That is the case of low-flash oil, out of which the fortune of at least one American multi-millionaire has been delved. Mr. Balfour's Government, in their wisdom, fixed the flash-point at 73 degrees, whereas the London County Council held that the minimum should be at least 100 degrees. This difference, formally sanctioned by the Legislature of the United Kingdom, helps to enrich American oil-trusts at the cost of the lives and property of English consumers. Statistics show that last year twenty-three lives were lost in London alone through the use of low-flash oil, while during the period from July, 1890, to March, 1900, there occurred from the same cause 2,055 accidents, of which no less than 250 were fatal. The whole question demands instant attention at the hands of any Government solicitous of the safety of His Majesty's subjects.

### The Abuse of Out-patient Departments.

WHENEVER any unfortunate oversight of hospital administration takes place a cry of horror is at once raised by a certain section of the public Press. No one can say that the administration of the medical charities is free from many a serious flaw and abuse, but, on the other hand, it may reasonably be urged that, considering the vast amount of good that is

affected, there is a wonderfully small margin of serious blunder. But there are two sides to every question, and in the present case the public have themselves to thank for many of the evils of which they so bitterly complain. Overcrowding lies at the bottom of ninety-nine out of every hundred of those unfortunate incidents that figure in the newspapers under the heading of "Another Hospital Scandal." Attendants, nurses, house surgeons, and medical staff find themselves swamped day after day with an endless array of work. The out-patient rooms contain scores of patients who ought to be under the care of private practitioners. Every morning hundreds and hundreds of patients from the suburbs and neighbouring county pour into the general hospitals of any great town, where, as often as not, they are treated by junior house surgeons or by students. Then, again, many a well-to-do person who is treated at a hospital for some surgical accident, returns thither for the whole course of treatment instead of going to a private medical attendant. Abuses of this kind it is clearly within the power of the public to control. Some day, no doubt, the out-patient departments of hospitals will be rigidly reserved for their proper duty, namely, to relieve the medical necessities of the poor.

#### PERSONAL.

**SURGEON-GENERAL W. TAYLOR, M.D., C.B.**, whose appointment to the Headquarters' Staff in London we referred to in our last issue, has now been appointed an honorary Physician to the King.

**THE Liverpool School of Tropical Medicine** learns that Major Ross is returning temporarily to England from Sierra Leone to arrange for the despatch of an expedition, similar to that now under his charge, to the Gambia and Gold Coast.

A **MASSIVE** and handsome marble fountain was unveiled last week at Saddleworth to the memory of the late Dr. Ramsden, who had resided at Saddleworth for thirty-six years. This fountain was erected by the public in token of their profound respect.

**LIEUT.-COLONEL F. W. TREVOR, M.B.**, Royal Army Medical Corps, has been gazetted to the local rank of Colonel in South Africa whilst Principal Medical Officer of a Division, and the following officers of the R.A.M. Corps to the local rank of Colonel in South Africa whilst Principal Medical Officers of General Hospitals:—Lieut.-Cols. J. L. Hall, G. H. Sylvester, G. E. Twiss, and F. A. B. Daly, M.B.

**THE grant of the local rank of Colonel in South Africa** made to the undermentioned officers of the R.A.M. Corps is continued to them whilst holding special appointments.—Lieut.-Colonel J. D. Edge, M.D., Principal Medical Officer Johannesburg District; Lieut.-Colonel J. A. Gormley, M.D., whilst Principal Medical Officer of a General Hospital; Lieut.-Colonel J. C. Dorman, M.B., whilst Principal Medical Officer, Eastern Line, Transvaal; Lieut.-Colonel A. T. Sloggett, C.M.G., whilst Principal Medical Officer of a General Hospital.

**THE will of the late Dr. McKim, Kelvingrove Street, Glasgow, has just been proved at over £22,000.** Dr. McKim was a bachelor, and died quite recently at an extreme old age. He had retired from the active duties of his profession for a number of years. He was a typical Highlander, and his practice was largely among the Highland people of the city, by whom he was much esteemed and his memory is greatly revered. Although possessed of ample means he lived a quiet and unpretentious, but, at the same time, a very useful life.

#### Correspondence.

[We do not hold ourselves responsible for the opinions of our correspondents.]

#### THE PROPOSED BRITISH AND COLONIAL JOURNAL OF OBSTETRICS AND GYNÆCOLOGY.

*To the Editor of THE MEDICAL PRESS AND CIRCULAR.*

**SIR.**—It is quite unnecessary to reply in detail to the plausible, if somewhat prolix, letter of Dr. Sinclair, which appeared in your issue of the 14th inst. His natural desire to be the originator of what he hopes will be regarded as an "Imperial Journal of Obstetrics and Gynæcology" would obviously find expression in the steps which he took to bring his "venture" to a successful issue, and found a journal which should be in the future, as certainly it has been in its incipency, associated with his name.

It is obvious from Dr. Sinclair's account of the main obstacles to his project, that these were to be found in the "apathy" and "hostility" among "certain circles of London gynæcologists," and from "quarters" which evidently were not taken into consideration by Dr. Sinclair when he worked out his scheme, to which however, as he states in his letter, he found "many opponents" "entirely unexpected." Further, it is evident that he associates such opposition with the British Gynæcological Society, or at least with "its most influential members" residing in London, an opposition which he is kind enough to say is "highly creditable to their loyalty," referring, I assume, to their relation to their Society and their journal.

Now, Sir, this is exactly the point at issue, namely, Dr. Sinclair's ideas of "loyalty" to a Society of which he is a Fellow, and those of other fellows of the Society differently circumstanced to him, and who happen to take a different view of its interests and relations to other Societies. That his action was regarded at least with suspicion, is evident from the quotation Dr. Sinclair gives from one of its most respected and influential members, who "declined to move without fully understanding how the Gynæcological Society was likely to be affected."

There was a rumour, possibly not the outcome of "unconstrained conversation and gossip only," that the proposed journal was the first step towards the formation of a new Gynæcological Society, which would, in time, swamp the British Gynæcological. Will Dr. Sinclair say if he never contemplated the formation of such a society? If memory serves me rightly, I think he put forward such a scheme in a letter which he wrote to the *British Medical Journal*. How would the Fellows of the British Gynæcological Society regard their participation, under the cover of promoting the success of a journal, in a movement which might ultimately tend to the assassination of their Society? This would mean a little more to it than the starting of a rival journal!

Let me say plainly why "leading men in the Gynæcological Society resident in London rightly regard this movement with suspicion." I will put the reason briefly. Certain leaders of the Obstetrical Society of London, or, as they prefer to designate themselves, "the teachers of obstetrics" in London, have been, and are, the persistent antagonists of the Gynæcological Society, though a few of the more liberally-minded of them have not shown such animosity. The splendid

work done by the Gynæcological Society, and the distinction it has earned as the pioneer of modern gynæcological work in this country, may explain this. Its "Journal" is the standing record of that work. When, therefore, a proposition is made to start a new "Gynæcological Journal" it is most natural that the Fellows of the Gynæcological Society should inquire as to the relation that journal would hold to theirs, and further, how far the Fellows of their Society were invited to co-operate in view of what Dr. Sinclair terms "the unhappy differences among London gynæcologists." This "difference" every broad-minded man must deplore, and no one does so more than the writer.

When they find that they have been deliberately excluded, while the Obstetrical Society is largely represented, naturally they are inclined to hold aloof. And this is just what has happened. I saw the first printed invitation with the inviters' names, and with the exception of some few provincial Fellows (two from Ireland) there were no names on it of Fellows of the Gynæcological Society. Why was this, unless Dr. Sinclair had already concluded that the Fellows of the Gynæcological Society would regard his journal as inimical to the Society? Surely the proper way to have initiated a "Universal Imperial Journal" would have been to have had a truly "representative" meeting, summoned by as many of the leaders of one metropolitan society as the other, and to which the Fellows of the two leading societies should have been equally invited to attend. This would at once have shown the *bona fides* of the promoters, and have made the journal "representative of British gynæcology in the fullest sense." As this was not done, but a meeting held at which only "*friends of the scheme*" (the italics are mine) were allowed to be present, Dr. Sinclair will pardon the reiteration of my conviction that this journal has been "taken in hand mainly by those who are openly and avowedly hostile to the British Gynæcological Society and its journal," though I accept his avowal that there was no such hostility on his part intended in its conception. In conclusion, I would remind Dr. Sinclair that it does not follow that because the method of starting a journal is animadverted upon, that those who do so are necessarily its "opponents," nor in my previous letter did I assert or infer that the first meeting was a "*private*" one. I affirm that it was "one sided." This Dr. Sinclair himself admits. I certainly in no way "prophesied failure," but I did assert, and now repeat, that the method of launching the journal will prevent its being "in the truest sense representative of British obstetrics and gynæcology."

I am, Sir, yours truly,

A LONDON OBSTETRICIAN AND GYNÆCOLOGIST.

#### THE CONGRESS ON TUBERCULOSIS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In *The Times* of to-day (August 20th) there appears under the above heading a remarkable letter from Col. W. Le Poer Trench. This letter is certain to give rise to a correspondence; and this, no doubt, will receive the editorial attention it may call for at the hands of THE MEDICAL PRESS AND CIRCULAR. My object in writing is simply to emphasise what I have more than once referred to in your columns, the fact that a vast amount of ignorance and prejudice exists in the minds of the educated public with regard to the medical profession. Col. Le Poer Trench may be taken as a fair sample of his class. His letter shows that he is not highly intellectual, and that he is completely ignorant of medical science; but he is intelligent enough to be a colonel in the Army, and wealthy enough to be able to offer a contribution of £1,000 towards a public test of "Dr." Alabone's "Lachnanthes" treatment of consumption. Colonel Le Poer Trench seriously believes that owing to prejudice or professional etiquette or trade union rules framed by the General Medical Council and observed by the profession, a great discovery has been practically kept from the public since the suspension of "Dr." Alabone fifteen years ago, "with the result that many thousands pronounced hopeless and incurable under the recognised treatments have been left to die." Colonel Trench's argument

amounts to this, that Dr. Alabone was unjustly expelled from the profession for infamous conduct, whilst, in fact, the whole profession has been engaged in an infamous and murderous conspiracy in withholding from their dying patients a remedy likely to save them and restore them to health. Colonel Trench has not taken the trouble to investigate even those questions involved upon which he is competent to form an opinion. Had he done this he would have learnt that no reputable medical man professes to hold and to purvey secret remedies; to do so constitutes infamous conduct. Every discovery, every advance in medical science, is made public; every supposed new remedy fully described so that it may be tested and tried by all inclined to do so. Tuberculosis causes 60,000 deaths annually in these islands; if anyone has discovered a drug or combination of drugs capable of curing this malady in any stage, let him make known the composition of his remedy, and if it stands the tests of science he need not fear that wealth and honour will not be showered upon him, not only in his own land, but in every country where tuberculosis claims an equal, or greater number of victims. Col. Trench's letter is a tissue of misconceptions from beginning to end; but these misconceptions could not have been entertained by anyone not grossly ignorant of the constitution of our profession, of its government, of its written and unwritten laws, and of the moral tone which characterises the bulk of its members and raises them far above the trades union level upon which Col. Trench places them.

I am, Sir, yours truly,

August 20th, 1901.

UBIQUE.

#### Obituary.

##### DR. A. LAWSON KELLY, OF GLASGOW.

WE regret to announce the sudden death of Dr. Adam Lawson Kelly, 26 Blythswood Square, Glasgow. He suffered from cardiac disease which necessitated him giving up professional work for over a year. His health had so much improved, however, that he sometime ago resumed work. A few days ago he was walking in Renfield Street when he was observed to fall by a policeman, who had him removed to the Central Railway Station, quite near. No professional skill was of any avail. Dr. Kelly, who was 65 years of age, was held in the very highest esteem by all with whom he was brought in contact, lay and professional friends alike. One of his sons is a medical man practising in the city. He has left a widow and grown up family to mourn their irreparable loss. The universal regard in which he was held makes his death to be very deeply deplored by all who knew him.

#### Medical News.

##### An Octogenarian's Violent Death.

AN inquest was recently held at Berwick on the body of Dr. David Cahill, aged over eighty, who was a graduate of Edinburgh University, and recently celebrated his jubilee as a medical practitioner. He died as the result of a fractured thigh, alleged to have been caused through his being assaulted and knocked down by Henry Gardiner, of the Cock and Lion Tavern, Berwick. After a four hours' sitting, the jury found that the doctor met his death by falling or being pushed down by Gardiner, but that the latter acted in self-defence as he had been struck with a stick by Dr. Cahill.

Dublin Death-rate.

THE deaths represent an annual rate of mortality of 20.6 in every 1,000 of the population for the week ending Saturday, August 17th. During the thirty-three weeks ending with Saturday last the death-rate averaged 27.2. It is interesting to note the beneficent effects on the mortality rate in Dublin of sunshine as the poor people in fine weather practically live in the streets, and the doors and windows of the fever dens of the city, euphemistically called unfurnished lodgings, are open to sunlight and fresh air. Uncertified deaths are still numerous. Ten such occurred during the week, and of

these eight were children, seven of whom were under one year of age.

**Failure of Water Supply.**

LEIGH-ON-SEA is unfortunate in the matter of its water supply. Twelve months ago the town was without water for no less a period than three weeks, an unpleasant experience that does not appear to have warned the local Council to set their house in order. Through another breakdown in the waterworks it is announced that the town is once again without water. The inconvenience caused by this failure is extreme, inasmuch as the place is full of visitors. The damage likely to be caused to a rising watering-place by recurrent water famines is obvious, and its full meaning is likely sooner or later to be brought home to the powers that be in the matter of the water supply of Leigh-on-Sea.

**Small-pox Outbreak in London.**

NUMEROUS cases of small-pox are being reported from various parts of London. During last week there were thirty-five patients under treatment for that disease in the hospital ships and wharf shelters of the Metropolitan Asylums Board, being an increase of twenty over the previous week. For several years London has been almost free of small-pox. The present outbreak will be watched with a good deal of interest because of the known hostility of some local governing bodies, notably that of Whitechapel, to vaccination, and also on account of the new generation of unvaccinated infants that is being yearly added to the population unprotected against small-pox by Mr. Balfour's Vaccination Act.

**The Mortality of Foreign Cities.**

THE following are the latest official returns, and represent the last weekly death-rate per 1,000 of several of the populations:—Calcutta 83-60, Bombay 48, Madras 41, Paris 18, Brussels 16, Amsterdam 15, Copenhagen 14, Stockholm 15, Christiania 23, St. Petersburg 30, Moscow 30, Berlin 20, Hamburg 25, Breslau 81, Munich 20, Vienna 17, Prague 22, Buda-Pesth 19, Trieste 21, Venice 17, Cairo 38-43, Alexandria 33 38, New York (including Brooklyn) 24, Philadelphia 18.

**Pass Lists.**

**Royal Colleges of Physicians and Surgeons, London.**

THE following candidates passed the second examination of the board in anatomy and physiology at the recent quarterly meeting of the examiners:—

E. F. Rimington Alford and James Armstrong, of Univ. Coll., London; Berkeley N. Ash, St. Barts. Hosp.; Cecil K. Attlee, B.A.Camb., St. Thomas's Hosp.; J. Landells Blake and Frederick J. Borrie, Otago Univ. and Middlesex Hosp.; John H. Burridge, King's Coll., Lond.; Arthur H. Bond and Harold Clapham, St. Mary's Hosp.; William Byam and H. G. Shaokleford Courtney, St. George's Hosp.; Thomas C. A. Cleverton, London Hosp.; Robert H. Cotton, St. Thomas's Hosp.; Walter Crampton, Univ. Coll., Liverpool; A. Marcellus De Silva, Ceylon Med. Coll. and London Hosp.; W. Leonard Dickson, Middlesex Hosp.; Kenneth A. C. Doig, Westminster Hosp.; William S. Edmond, St. Barts. Hosp.; Evan E. Evans, Univ. Coll., Liverpool; Harry L. Evans and Charles B. B. Eyre, St. Thomas's Hosp.; Harry A. Fenton and Walter T. Finlayson, St. Mary's Hosp.; George E. O. Fenwick, Otago Univ., New Zealand, and Univ. Coll., Lond.; Harold N. Fink, B.A.Camb., and David H. Fraser, B.A.Camb., Camb. Univ.; William H. France, Westminster Hosp.; Edgar H. Geod, London Hosp.; G. Christopher Grundy, Yorks. Coll., Leeds; Percy Gully, Charing Cross Hosp.; Arthur L. Heiser and Daniel M. Humby, L.D.S.Eng., Middlesex Hosp.; George W. Heron, Westminster Hosp.; Cecil D. M. Holbrook, Hugh M. Huggins, and Algernon M. A. James, St. Barts. Hosp.; Thomas M. Hughes and William H. Kaye, Owens Coll., Manchester; A. Hilderbrand Jacob, London Hosp.; Henry H. Jenkins, Guy's Hosp.; Tikiri B. Kobbekaduwa, Ceylon Med. Coll. and Univ. Coll., London; Harold A. Kisch and George M. L. Lester, M.A.Oxon., St. Thomas's Hosp.; John E. Lascelles, St. Mary's Hosp.; St. Brown-

ing Lethbury, St. Barts. Hosp.; Frederick B. Lowe, William N. May, Percy F. Minett, C. Sculthorpe Morris, L.D.S.Eng., and Maurice J. Mottram, Guy's Hosp.; W. Cameron Macaulay, B.A.Lond., Middlesex Hosp.; J. C. Stuart McDougall, Otago Univ., New Zealand; Philip J. Marett, Westminster Hosp.; Aurelius V. Maybury, Durham Univ. and Guy's Hosp.; Roy C. Merryweather, Univ. Coll., Lond.; Echlin S. Molyneux and Idris N. Morgan, London Hosp.; Harold E. Moxon, St. Thomas's Hosp.; Alexander H. Muirhead, Francis M. Newton, and Charles W. O'Brien, St. Barts. Hosp.; Hamish Nicol, Westminster Hosp.; Gerald Nunn and Edward C. Peers, Guy's Hosp.; George B. Panton, London Hosp.; George A. Paulin, Royal College of Surgeons, Edinburgh; Christopher T. Fellow, St. Thomas's Hosp. and Cooke's School of Anatomy and Physiology; Alan F. C. Pollard and H. Hammond Rolfe, St. Barts. Hosp.; George H. Rains, Westminster Hosp.; Cecil E. Reynolds, Univ. Coll., Lond.; Cyril S. S. Rigby, Birmingham Univ.; Alexander Ruete, Univ. Coll., Liverpool; Griffith H. Rees, Gerald C. F. Robinson, Frederick Rogerson, Richard P. Rowlands, and Randolph St. G. Seagrove, Guy's Hosp.; Edward A. Smith, Univ. Coll., Liverpool; Edward J. R. Surrage, B.A., LL.B., and Cecil Vosper, King's Coll., Lond.; Herbert B. Scott and J. E. L. Alexander Turnly, B.A.Camb., St. Barts. Hosp.; Kenji Takaki, St. Thomas's Hosp.; Francis Thompson, Alfred G. Tresidder, James Turtle, Albert J. Walton, Thomas J. Williams, John H. Wolfe and Percy C. Wollatt, London Hosp.; Alfred E. Weaver, Birmingham Univ.; Salomon J. Weinberg, Owens Coll., Manchester; Arthur D. White and Frank E. Whitehead, St. Barts. Hosp.; Edward K. Williams, B.A.Camb., St. Andrew's Univ.; James A. Williams, Univ. Coll., Lond. Mr. Alexander V. Benson, London Hosp., passed in physiology only.

**Society of Apothecaries of London.**

THE following candidates have passed in:—

Surgery.—J. C. Baggs, Section II.; P. C. Burgess, Section II.; D. Fletcher, F. I. M. Jupe, G. J. W. Keigwin, Sections I. and II.; E. R. Risien, Section II.; W. B. Skelton, M. J. Williams.

Medicine.—J. W. W. Adamson, Section I.; J. H. Beasley, Sections I. and II.; R. C. Bennett; C. E. H. Leggatt, Sections I. and II.; E. T. Longhurst; D. J. Morgan, Sections I. and II.; E. Osborne, Sections I. and II.; J. E. Skey, Section II.; A. W. D. Thomson; P. P. Tobit, Section II.

Forensic Medicine.—J. W. W. Adamson, R. C. Bennett, H. A. Chaplin, C. E. H. Leggatt, E. T. Longhurst, D. J. Morgan, E. Osborne, A. W. D. Thomson, P. P. Tobit, S. C. Wilkinson.

Midwifery.—R. C. Bennett, T. S. Davies, J. W. H. Morrison, E. S. Perkins, R. Rees, S. C. Wilkinson, F. W. B. Young.

The L.S.A. Diploma of the Society was granted to the following candidates, entitling them to practise medicine, surgery, and midwifery: J. C. Baggs, E. T. Longhurst, D. J. Morgan, J. W. H. Morrison, E. S. Perkins, E. R. Risien, W. B. Skelton, A. W. D. Thomson, and M. J. Williams.

**Indian Medical Service.**

THE following is an official list of the candidates for His Majesty's Indian Medical Service who were successful at the Competitive Examination held in London on February 9th, 1901, and following days, arranged in the order of merit as issued from the India Office, August 20th:—

	Marks.		Marks.
Lister, A. E. J.	... 3,246	Bradley, R. J.	... 2,633
Williams, T. F. B.	... 3,135	Loch, E. A. ...	... 2,593
Abbott, S. H. L.	... 3,077	Carter, R. M.	... 2,550
Greig, A. W....	... 3,015	Hagger, R. L.	... 2,545
Lloyd, R. E. ...	... 3,013	Baker, D. G. E. S.	... 2,500
Woods, J. ...	... 2,965	Harley, T. W.	... 2,472
Steen, H. B. ...	... 2,940	McCoy, J. W.	... 2,306
Munro, D. ...	... 2,929	Willcocks, R. A.	... 2,264
Bisset, E. ...	... 2,910	Paterson, T. G. F.	... 2,220
Clements, J. E.	... 2,890	Rai, D. G. ...	... 2,207
Overbeuk Wright, A.			
W. ...	... 2,665		

## Notices to Correspondents, Short Letters, &c.

**CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

**REPRINTS.**—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the publisher or printer before the type has been distributed. This should be done when returning corrected proofs.

**ORIGINAL ARTICLES** or **LETTERS** intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication, but as evidence of identity.

**READING CASES.**—Cloth board cases, gilt lettered, containing twenty-six strings for holding the numbers of THE MEDICAL PRESS AND CIRCULAR, may now be had at the office of this journal, price 2s. 6d. These cases will be found very useful to keep each weekly number intact, clean, and flat after it has passed through the post.

### INCREASE OF HYDROPHOBIA IN PARIS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR, — I am greatly surprised that deaths from hydrophobia in Paris have not reached a higher figure, seeing that there is in that city a huge Pasteurian Institute largely dependent for its prosperity upon the sale of anti-rabic serums and upon a constant influx of dog-bitten patients. Common sense will supply the links in the chain of this argument.

I am, Sir, yours truly,  
FRED. E. PIRKIS.

Nutfeld, August 23rd.

DR. S. B. (Bedford).—Appendicitis in infancy is not unknown, although it is extremely rare. A case was recently recorded in an American journal, in an infant of three months' old. About sixteen cases in all have been published, of which nine were operated upon, with seven recoveries.

WESTPHALIA.—The total population of Greater London, including the outer ring of suburbs, is now 6,578,984.

M.B.C.S. (Exeter).—Our correspondent's letter is not explicit enough. Nor can we gather when the occurrence described in the newspaper cutting which is forwarded took place, inasmuch as no date is appended.

M. D.—Undoubtedly the attention of the Royal College of Physicians, London, should be called to any Fellow of the College who could be proved to be a shareholder in one of the many sanatoria now exploited for the open-air treatment of tuberculosis. Whether, however, the College would take action or not remains to be seen.

DR. BERNARD (Birmingham).—Copies of the souvenir volumes which were presented at the festival dinner of the Royal College of Surgeons (England) last year, can now be purchased from the Secretary of the College, at 5s. per volume.

### AN INVALID EXCUSE.

"No," said the doctor, "I haven't voted yet, and I am not going to vote. I am not feeling well to-day. Isn't that a valid excuse?" "Not at all," responded the professor severely. "That's an invalid excuse."—*Chicago Tribune*.

E. A.—We were unable to publish your former contributions because the language was so involved as to render the meaning dubious.

**BACTERIOLOGIST.**—The subject is not one to the discussion of which we feel disposed to open our columns.

**YOUNG MEDICO.**—With capital at hand it would be more expedient to take a house and put up a brass plate, and wait for practice in a likely neighbourhood than to embark upon a partnership under the circumstances named by our correspondent.

**BONDHOLDER.**—The custom is founded upon strict equity.

### THE GEOGRAPHICAL DISTRIBUTION OF CANCER.

Y. M. W.—Much useful information in regard to the distribution of cancer in Great Britain will be found in Mr. Alfred Haviland's "Geographical Distribution of Disease." The proposal to compile "cancer maps" is not a novel one, and might be advantageously carried out, especially as the cost would be trifling having regard to the importance of the question involved.

**OMEGA.**—Several cases of dermatitis from wearing stockings impregnated with arsenic have been recorded.

**ASSISTANT.**—The proposal seems to us to be scarcely consistent with the justice of the case, and we cannot advise our correspondent to accept it.

**ETIQUETTE.**—The necessary bond must be given, otherwise the negotiations must fall through.

**COLONIAL SURGEON.**—Apply to the Dean of the West London Post Graduate College, West London Hospital, Hammersmith, W.

DR. E. S.—We have made inquiry, but have been unable to ascertain the present address of the gentleman, the subject of your letter. He is probably still at the front, or thereabouts.

## Appointments.

BEALE, H. E., M.B.C.S., L.R.C.P.Lond., Assistant Resident Medical Officer to the General Infirmary at Leeds.  
DAVIES, W. N. M.D.B.U.I., Certifying Surgeon under the Factory Acts for the Llantrisant and Llanwit Fardre Rural District.  
EVANS, D. E., M.B., B.S.Lond., Certifying Surgeon under the Factory Acts for the Pontypridd Urban District.  
GRUNER, O., M.B.C.S., L.R.C.P.Lond., has been appointed House Physician to the General Infirmary at Leeds.  
HUNTER, WILLIAM, M.B., C.M.Aberd., Assistant Director of the Pathological Institute, London Hospital.  
POTTS, E. THURLOW, M.B., Ch.B. Edin., Resident Medical Officer for Sick Children, Newcastle-on-Tyne.  
RAW, NATHAN, M.D. Durh., F.R.S.E., D.P.H., Visiting Medical Superintendent to the West Derby Union Infirmary, Liverpool.  
SMITH, C. LAWSON, M.B., Ch.B.Aberd., Senior Resident Medical Officer to the Tottenham Hospital.

## Vacancies.

Birmingham Workhouse Infirmary.—Assistant Resident Medical Officer. Salary £100 per annum, with apartments, rations, coals gas, laundry, and attendance. Immediate applications to the Clerk to the Guardians.  
Bradford Royal Infirmary.—Dispensary Surgeon, unmarried. Salary £100 per annum, with board and residence. Also Junior House Surgeon, unmarried. Salary £50 per annum, with board and residence.  
Cheshire County Asylum, Parkside, Macclesfield.—Senior Assistant Medical Officer, unmarried. Salary £175, rising to £200 per annum, with board, apartments, washing, and attendance.  
County Asylum, Lancaster.—Assistant Medical Officer, unmarried. Salary £150, increasing to £200, with apartments, board, washing, and attendance.  
County Borough and Port of Southampton.—Medical Officer of Health, Port Medical Officer, and Medical Superintendent of Infectious Diseases Hospitals. Salary (combined offices), £500 per annum.  
Cumberland Infirmary, Carlisle. Resident Medical Officer. Salary at rate of £80 for first six months, and £100 second six months per annum respectively, with board, lodging, and washing.  
East Riding of Yorkshire.—County Medical Officer of Health. Salary at rate of £400 per annum, rising to £500 per annum, with allowances. (See advt.)  
Glamorgan County Asylum, Bridgend.—Assistant Medical Officer, unmarried. Salary £175, with board, lodging, attendance, and laundry.  
Glasgow University.—Additional Examinership in Medicine and Science. Annual emolument £30. Duties to commence in January, 1902. (See advt.)  
Great Northern Central Hospital, London.—Vacancies for House Physician. Salary £60 per annum; Junior House Physician, Salary £30. Board, residence, and washing provided in each case. Also Junior House Surgeon, Salary £30, with board, residence, and washing; and a non-resident Assistant House Surgeon, with Salary at rate of £30 per annum, and partial board. Full particulars of these vacancies will be found in our advertisement columns.  
Kasr-el-Ainy Hospital and School of Medicine, Cairo, Egypt.—Physician to the Hospital and Professor of Clinical Medicine at the School. Salary £E320 per annum and private practice allowed.  
Metropolitan Asylums Board.—Assistant Medical Officer, unmarried, at the Fever and Small-pox Hospitals. Salary £160 per annum, rising to £200, with board, lodging, and washing.  
Northampton General Infirmary.—House Physician (unmarried). Salary £100 per annum, with apartments, board, attendance, and washing.  
Notts County Asylum.—Temporary Assistant Medical Officer. Four guineas per week, with board, lodging, attendance, and washing.  
Owens College, Manchester.—Junior Demonstrator in Physiology. Salary £100, rising to £150 per annum.  
Scarborough, (Borough of).—Medical Officer of Health. Salary £325 per annum, rising to £375 per annum. Full particulars on application to the Town Clerk.

## Births.

FRANCIS.—On August 20th, at Arnold, Notts, the wife of Harvey Francis, M.D., of a son.

## Marriages.

RICHARDSON—MANSELL.—On August 20th, by the Rev. A. E. Mansell, M.A., brother of the bride, Walter Silverwood Richardson, M.D., M.B.C.S., of Melbury, Boscombe, youngest son of T. Richardson, M.D., M.B.C.S., of Highbury New Park, to Ada Mary, youngest daughter of Thomas Henry Mansell, of Temple Balsall, Warwickshire.

WILD—ZWEIFEL.—On August 22nd, at Zurich (Switzerland), Robert Oscar Wild, M.D., eldest son of Franz Wild, of Freiburg-i/B., to Maria Ida, youngest daughter of Henry Zweifel, of Zurich, formerly of Palace Road, Streatham Hill, London, S.W.

## Deaths.

BAKER.—On August 21st, in London, Thomas Young Baker, Brigade Surgeon, Army Medical Staff, Retired, youngest son of the late Rev. W. Lake Baker, Rector of Hargrave, Northamptonshire.  
CESAR.—On August 21st, at Danecale Lodge, Sheppey, Kent, Gerard, and on the 22nd, Eric, the infant twin sons of Julius Cesar, F.R.C.S.L.

# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXIII. WEDNESDAY, SEPTEMBER 4, 1901.

No. 10.

## Clinical Lecture ON HYDROCELE. (a)

By A. MARMADUKE SHEILD, M.B., F.R.C.S.,  
Surgeon to St. George's Hospital; Consulting Surgeon to St. John  
and St. Elizabeth Hospital.

BEFORE discussing the diagnosis of hydrocele, a word must be said about *causation*. This is summed up at once by declaring that in a large number of cases of hydrocele no certain cause can be assigned for the disease. The books say that hydrocele is due to a loss of the balance between the absorption and secretion of fluid in the tunica vaginalis, but the fact remains that in a considerable number of cases of hydrocele the sac of the tunica vaginalis is distended with fluid without any rational cause being assignable. A very suggestive point is as follows: A certain number of cases of hydrocele are associated with definite disorders of the testicle. Thus, in syphilis of the testicle, concomitant hydrocele is familiar. In tubercle of the testicle, malignant disease of the testicle, chronic orchitis and epididymitis due to catheterisation, hydrocele is also found, though far more rarely. Thus a certain number of cases of hydrocele are undoubtedly caused by the spread of inflammation to the tunica vaginalis from the testis, or rather from the epididymis. This suggests that hydrocele is usually inflammatory in origin, which is very important in the matter of treatment, for the method of curing hydroceles dependent upon syphilis or tubercle of the testis, is largely bound up in the treatment of the testicular affection which causes and underlies the hydrocele. In some hydroceles a small pedunculated body is found near the head of the epididymis. This is a fetal relic and is sometimes found in the tunica when no hydrocele is present. It is to be wondered whether the rubbing of this substance against the serous surface might produce excess of secretion. The analogy of serous exudation in the knee, due to the rubbing of a pedunculated body from the edge of the cartilage, seems very close.

The *symptoms* of the ordinary hydrocele of the tunica vaginalis, such as are often met with in the out-patient department of a hospital or in private practice, are really exceedingly simple. First of all the shape of the swelling at once tells that it is a distended tunica vaginalis. The swelling is pear-shaped and the neck of it is narrow, so that the cord can be distinguished above the swelling by the pressure of the thumb and finger, showing that no hernia exists, and that it is definitely isolated from the abdominal cavity. Large hydroceles have often a slight constriction about their centre, "hour-glass contraction," which is also very characteristic. There is no impulse on coughing; the swelling cannot be reduced into the belly; and it is very generally translucent. In the vast majority of cases of ordinary hydrocele the position of the testicle is behind the collection of fluid. As a rule the patient is able to distinguish testicular sensation when this part of the swelling is squeezed. It is advisable never to carry out such an

examination, for patients' statements can rarely be relied upon as to their sensations, and a careful examination by transmitted light will usually show the position of the testis by the opacity produced. In a large hydrocele, moreover, the volume of the fluid is so great that it is generally impossible to feel the testis at all, still less to squeeze it. In a few instances of hydrocele the testicle is in front of the hydrocele. This unusual circumstance may be due to malposition of the testicle, the epididymis being in front instead of behind. It may also be caused by the "anchoring" of the testis to the front of the sac by inflammatory adhesions. Thus this condition is found in old hydroceles, which have been tapped many times, and perhaps fruitlessly injected.

The fluid which is contained in hydroceles is highly albuminous, and is generally of a pale straw colour. In some cases of old hydroceles, which have existed for many years, the fluid becomes more opaque and mixed with cholesterin, the colour of old ale, which may greatly mar the certainty of the "translucency" test. Hydroceles associated with sarcomatous testis may contain bloody fluid. It would be more correct to call them hæmatoceles, except that the serum is often in great excess over the blood mixed with it. The fluid in a hydrocele is as a great rarity chylous, and in a case of chylous hydrocele which came from abroad the presence of filaria in the lymphatics was suspected by experts.

All hydroceles are not translucent. Those which have existed for a great many years, and have, perhaps, been tapped many times, and have become chronically inflamed, are notably not transparent. The sac in such cases, from repeated inflammatory attacks, may attain to a great thickness. Such a swelling will be non-translucent, and the diagnosis may be puzzling enough, unless a clear history, of long duration and frequent tapplings be obtained. "Histories" are very deceptive, and sometimes these cases can only be cleared up by exploratory incision. The only way of certainly diagnosing hydrocele with thick walls is by an exploratory incision. It is impossible to distinguish a hydrocele with thick walls from an old hæmatocele except by cutting into it. A swelling may be a hydrocele at one tapping, a hæmatocele at the next, the trocar having pierced a vein, which slowly oozes into the cavity. In these opaque swellings, too, the position of the testis is very problematical. There are frequently inflammatory adhesions, which displace the organ. Hence the incision is safer than the trocar, for the latter may pierce the testis, and lead to the erroneous conclusion that there is a solid tumour.

Confusion between ordinary vaginal hydrocele and soft sarcoma of the testicle ought, in reality, never to occur. Soft sarcomatous growth of the testicle is, on the whole, rare; hydrocele is very common. Soft sarcomatous growth of the testis is non-translucent; it is heavy when lifted up on the hand. It feels solid in some parts, fluctuating in others. The scrotal veins are much enlarged, and the cord above is thickened. An exploratory incision immediately clears the matter up, because instead of opening into a cavity containing fluid, a vascular brain-like tumour is found. The appearance of the patient must not be taken into

(a) Abstract of a Clinical Lecture delivered at St. George's Hospital, London.

account. Large malignant growths of the testis may be found in persons who have the appearance of perfect health.

Ability to feel the elements of the cord above the swelling is the main differential symptom on which to rely in the diagnosis of common hydrocele from hernia. But the shape of the neck of a hernia is different from that of a hydrocele. In hydrocele the swelling is definitely cut off from the abdomen at the external abdominal ring; in hernia there is a wide neck which passes up into the abdomen, distending the inguinal canal.

The treatment of hydrocele is very variable. In a large number of instances, the patients will be satisfied with the swelling being tapped at certain periods. This is termed the palliative treatment of hydrocele, namely, performing paracentesis when the swelling gets inconvenient from its bulk. This operation should be done with an exceedingly fine and sharp trocar and cannula. The patients will appreciate the use of a fine instrument. The hydrocele trocars sold in the shops are often too large for use by a sensible and humane surgeon. The skin of the scrotum should be carefully cleansed, and the instrument boiled before and after using. The sac should be made very tense by the pressure of the left hand before the trocar is introduced, and a spot should be selected free from veins. Radical cure of hydrocele dependent upon disease of the testicle should not be attempted. Under such circumstances it would be unwise to undertake, for instance, the injection method; the diseased testis would be left, and, perhaps, the mischief in it aggravated by the irritant fluid. Tapping is often employed in hydrocele associated with testicular disease, and indeed is sometimes essential in diagnosis. Not until the fluid be withdrawn can the surgeon properly feel the enlarged testis, and estimate its nature.

Another case where the injection cure should not be attempted is where there is a very thick sac. Iodine injected into a hydrocele with very thick walls only makes matters worse. Again, radical cure by injection should never be attempted where there is communication between the sac and the abdominal cavity. Such hydroceles are found in young infants and boys (congenital hydrocele). Many hydroceles in the very young, however, are quite ordinary, and do not communicate with the belly.

One of the objections to radical cure by injection of iodine is its uncertainty. It has been computed by some authorities that 20 or 25 per cent. of the cases of hydrocele treated by injection are not cured. Another objection to injection, especially with iodine, is that the epididymis is generally inflamed by it, and so for weeks after the injection there is a painful, indolent swelling of the testis and epididymis, set up by the injection. The injection is very painful when the iodine enters the tunica vaginalis. Patients have not infrequently been known to faint. Injection of iodine is a remedy which is practised largely, especially in hot countries like India, where hydroceles are very common and very large.

It is important to draw off all the hydrocele fluid; a very common error is to leave several drachms of hydrocele fluid in the sac, and thus when the tincture of iodine is thrown in it probably gets diluted. Many of the instances of "recurrence" after injection may be explained by some faulty procedure on the part of the operator. One to two drachms of the Edinburgh tincture of iodine, which is rather stronger than the usual preparation, is injected into the cavity of the sac. The next step is to shake the sac well, so that the iodine is diffused all over it. This may be acutely painful, and it is wiser to perform the operation with the patient lying down on a sofa. Some surgeons make a practice of previously throwing into the sac of the tunica vaginalis a 2 per cent. solution of cocaine. Not more than a quarter of a grain should be introduced, but it certainly diminishes the smarting caused by the iodine. The day following the injection the scrotum will be swollen and red, and the epididymis inflamed and tender. The patient will sometimes complain of very great discomfort, so that he has to be kept in bed for a few days, though this is

unusual. As a rule, there is more or less epididymitis, and a chronic indolent swelling results, which only slowly subsides.

An injection which, perhaps, is becoming more popular than iodine is carbolic acid. This is at least as likely to cure as iodine, and it is very much less painful. Having emptied the hydrocele, 40m to a drachm of a mixture of equal parts of liquefied carbolic acid and glycerine are thrown into the sac. The scrotum is shaken after injection, so that the whole sac comes into contact with the remedy, and a cure is generally the result. Carbolic acid does not inflame the epididymis to the extent that iodine does, neither does it cause such severe pain. There are various other fluids recommended for injection into hydroceles. All of them, however, are inferior to iodine and carbolic acid.

The method of treatment which most modern surgeons perhaps advise for hydrocele is the radical cure by operation. It is an excellent proceeding in boys or young men who have to enter the services of the army and navy. If the radical cure by excision of the sac is performed, it necessitates resting in bed or on the sofa for upwards of a fortnight or three weeks. The operation is done in various ways. The first is the simple incision method. The hydrocele is incised, and the interior of the sac is lightly rubbed over with carbolic acid with a strength of one in ten; a drainage tube is then put in, and the incision sewn up. This is a good method for small hydroceles in boys. Then there is the method of excision of the sac. The sac of the hydrocele is exposed, and a considerable portion of the parietal layer of the tunica vaginalis is cut away with sharp-pointed scissors. The remaining portion, which covers the front of the testis, is lightly touched over with one in ten carbolic acid, or with a solution of nitrate of silver, twenty grains to the ounce, a drainage-tube is put in and the parts sewn together. The tube is withdrawn in twenty-four hours, and the part carefully dressed and elevated. A certain amount of inflammatory epididymitis will ensue. Especial care must be taken in replacing the organ in the scrotum that the cord is not twisted. This is easy enough to do, and it may lead to very unpleasant after-consequences. In both these procedures the strictest asepsis must be maintained in the dressing, and elevation of the part must be carried out carefully. It is necessary to guard against secondary hæmorrhage. In a big hydrocele the little vessels are very much stretched by the pressure of the fluid, and are diminished in calibre. As soon as the fluid is let out the vessels become engorged. Sometimes a little artery or vein will bleed very persistently into the loose scrotal tissues in these cases. Every single bleeding-point must be tied before uniting the wound and sending the patient back to bed, using ligatures of the finest catgut. If this is not done there may be troublesome secondary hæmorrhage into the scrotum, which becomes "blown up," and bluish in colour.

Male infants sometimes get hydroceles like their seniors, and the greatest alarm is manifested by the anxious female relatives. The symptoms of hydrocele in a baby are exactly the same as those in the adult. A little pear-shaped swelling is observed, which is readily translucent, light showing through it as a red glare. One of the first things to determine is whether the swelling is a congenital hydrocele, and if the fluid can be reduced into the abdominal cavity. If iodine or carbolic acid be injected into the hydrocele of a little child, the scrotum will inflame and may possibly slough, and the life of the infant may be endangered. This is not a fanciful danger. The mistake has been made in practice. The ordinary hydrocele of infants will not infrequently go away if it is left alone, but this will seldom satisfy the parents; they demand some active treatment. The first measure therefore to adopt is to paint the outside of the scrotum persistently with a slightly irritating lotion, such as chloride of ammonium—a saturated solution of the drug in rectified spirit and water. This remedy really cures very few of these cases, but it is harmless.



The next method is acupuncture. The scrotum is made tense, and a fine sharp needle is passed into the hydrocele in various situations; the fluid exudes in drops, and passes into the cellular tissue. This method is advocated in the text-books, but it is not a certain cure. In the case of a large hydrocele in an infant, especially if it has resisted other treatment, incision is the best method. Let out the fluid and rub the interior of the sac with a solution of nitrate of silver, ten grains to the ounce, or one in ten carbolic acid. This may be done by dipping the end of a probe into the "irritant," and passing it lightly over the surface of the tunica vaginalis. A small piece of gauze is inserted for the first twenty-four hours. If the sac is very large a portion of the parietal layer can be excised just as in the adult. The most careful asepsis must be maintained. This is practically very difficult; soaking in a warm boric bath is useful in these cases. There is another point about hydroceles in infants; it is as follows:—In certain hydroceles in little babies the sac goes a long way up into the inguinal canal, distending it, and simulating hernia. This is due to failure of obliteration of the lower part of the funicular process. This variety is called infantile hydrocele. A mere septum may separate the fluid from the abdominal cavity, and careful examination is needful to ascertain that the rupture is not really of the congenital variety, and that the fluid cannot be pressed slowly into the belly.

Encysted hydroceles of the epididymis are said to have their origin in dilatation of some of the fetal tubules which are found in that neighbourhood. The cysts do not, as a rule, attain to large dimensions—about the size of a hazel nut or a walnut. They are tightly distended with fluid, and are sometimes mistaken for solid swellings; indeed, the sensation to the hand is exactly like a double testicle. Whenever there is what seems to be a double testicle on one side, the case will probably turn out to be an encysted hydrocele. These remarkable swellings contain perfectly clear fluid, which is non-albuminous, and also a large amount of phosphates and carbonates. On the addition of nitric acid, effervescence occurs. But inasmuch as a seminal tubule frequently ruptures into them, they become full of spermatozoa, which may give them a milky appearance and spoil their translucency. Then the fluid, of course, becomes albuminous. The walls of these cysts may also be thickened, and this prevents translucency, and an exploratory incision may be needful to establish a certain diagnosis. They are treated in the same way as other hydroceles, namely, by injection, or radical cure by laying them open. Owing to their close connection with the epididymis, the cutting away of a portion of the sac is far the best method to adopt.

With regard to the treatment of congenital hydrocele, which is found in boys and young children, where the fluid can be reduced into the abdominal cavity it would be risky to inject these swellings, for the fluid might find its way into the peritoneal cavity and set up grave inflammation. It is difficult to advise regarding the treatment of congenital hydrocele. Great difference of opinion exists. Many surgeons recommend a truss, and state that the pressure of the pad obliterates the opening. This is always a dubious and tedious method. It is far better to perform an operation like that for radical cure of hernia, the incision being longer and lower down, tying the neck of the sac high up, and sewing together the pillars of the ring, and at the same time excise the front wall of the sac.

Hydrocele with enlarged testis, so-called hydrosarcocele, is often a puzzling condition. Hydrosarcocele is differentiated at once from hydrocele by the fact that when the swelling is lifted up it is extremely heavy, and on palpation the fingers will displace fluid, and come down with a sudden impact upon the solid mass inside. Hydrosarcocele may be non-translucent, except to a very limited degree in front. In the great majority of cases these sarcoceles are syphilitic, and are often bilateral. And the hydroceles may take very irregular form, being, indeed, mere collections of fluid limited by adhesions and false membrane. Hydrocele associated with tuberculous disease of the testis may be found. The hydrocele effusion is very often acute, and if a

young man has hydrocele which is painful and has formed within a month or six weeks it is almost always sure to be due to some disease of the testicle. Such hydroceles should be tapped and the testicle carefully palpated before giving a complete opinion or prognosis. In certain exceptional cases there may be large collections of fluid surrounding malignant disease of the testicle, and the fluid may be bloody. Incision will clear the diagnosis up. Again, old men who use the catheter often get chronic epididymitis and orchitis, and this condition may be associated with hydrocele.

In the treatment of hydrosarcoceles there is no objection to tapping provided care be taken not to wound the enlarged testis inside, and the patient will be considerably relieved. After drawing off the fluid with a fine trocar, if the case is syphilitic, the part should be strapped with blue ointment, and iodide of potassium given internally. In hydrosarcocele, when the testis is tuberculous, in removing the disease which causes it, the whole condition is cured. In sarcoma of the testis there is a progressively increasing swelling, which has probably dated from six to twelve months before, and it will be non-translucent. The story of a blow or "squeeze" is common enough. In addition, the veins over the scrotum are markedly enlarged, and there are frequently nodules of growth in the cord, and to the hand the swelling is very heavy. As soon as incision is made into it the nature of the growth is determined.

## A STUDY IN HEREDITY: IN ITS RELATION TO IMMUNITY IN TUBERCULOSIS.

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THE material for this study was taken chiefly from private practice, with the addition of a few cases occurring in the author's hospital service, whose opportunities for close observation at the time and personal knowledge of the subsequent histories of the several cases after leaving the wards were sufficient for the purposes desired. Some apology it would seem necessary to offer for presenting before such a body as this honourable congress deductions and conclusions based upon researches in so limited a number of cases as this present study includes, more especially since certain of the conclusions are at variance with traditional axioms in phthisiology. However, in the present inquiry all facts were collected and recorded personally and without prejudice, so that, however unique may be the conclusions to which a study of my cases has led, they are warrantable at least so far as the limit in number of observations will permit. The material at my disposal consists of carefully recorded histories of 242 cases of pulmonary tuberculosis. In every instance I have endeavoured, besides studying the influence of heredity and environment, to ascribe, whenever possible, a cause for such peculiar manifestations of the disease as became apparent, and also to establish the relation which certainly exists between the selective activity of the disease and hereditary influence.

The theory that a phthisical parentage predisposes the offspring to the disease by virtue of heredity, while very firmly grounded in the medical mind, and still more so, of course, in that of the laity, has nevertheless, I believe, always been a subject of more or less controversy, and especially since the isolation of the specific micro-organism. Without, however, entering upon a *résumé* of this controversy, which the limits of the present occasion and inclination alike prescribe, I have, like most phthisio-therapeutists, always been disposed to discredit the theory and, until within the last four or five years, to place a negative value upon "family history"

except in so far as a tuberculous parentage subjected an individual to additional risks of infection. The following instance, which came to my notice several years ago, first suggested to me that there might be a certain degree of *immunity* conferred to the offspring of phthisical parents. I published this instance as an illustration in 1898, in a paper in which I first ventured the opinion that "phthisical parents might impart to their progeny a certain immunity to the disease." (a) As it is brief and to the point I quote it:—"A clergyman and his wife, the latter having borne two children after developing pulmonary tuberculosis, took into their household by adoption the orphan child of a non-tuberculous family. After surviving the birth of her last child six years the wife died. Both of her children are living and in excellent health to-day, the younger having passed her twentieth year. The adopted child came under my observation at the age of seventeen years, having developed acute pulmonary tuberculosis from which she died."

To adopt as a working theory this idea of conferred immunity in tuberculosis against all traditions requires, I admit, considerable temerity. One is constantly confronted with the question of inherited predisposition and cannot fail to be influenced by the demonstrable fact of "percentage heredity," a term employed by Dr. J. Edward Squire, to express in percentage the difference between the number of the offspring of consumptive parents subsequently developing tuberculosis and that of the offspring of non-consumptive parents subsequently developing the disease. Dr. Squire's paper was published in November, 1897 (b), and was a most valuable contribution to the subject of hereditary influence in phthisis. In it he refers to a former paper, by himself, read before the Royal Medical and Chirurgical Society of London in December, 1894, on "The Influence of Heredity in Phthisis." Both papers were based upon results of thorough investigations in sufficient numbers of instances to warrant the adoption of his conclusions as *standards* in future inquiry along this line. I have no hesitation in accepting them as final so far as they are carried.

This "percentage heredity" Dr. Squire found to be only 9.51, and he points out that it is easy to explain this small percentage of influence due to parents by the additional risks of infection to which the children of phthisical parents are exposed. Now, it has seemed to me almost certain, that if these children of consumptive parents, especially that usually weak and under-nourished class from which Dr. Squire made his observations, were not in some manner protected, this percentage would be much larger, since in such cases we may take it for granted that all of them fulfil every required condition for the development of the disease. Therefore, while admitting the fact of a "percentage heredity," the very figures which express it are such as to support the theory of an hereditarily conferred immunity.

It is, I think, the rule to find among the children of consumptive parents poor nutrition, imperfect digestion, and other functional derangements, together with certain almost characteristic marks of degeneracy in the bony skeleton, the long, shallow, and comparatively immobile chest, prominent scapulae and sunken sternum. Yet with such features, more or less marked in a family of several children of consumptive parentage, it is a matter of common experience to see them all reach maturity without succumbing to an affection which, from the very nature of things, it would seem inevitable that they could not escape; while, on the other hand, the

more acute, unresisting, and progressively fatal cases, I think, it is the common experience to find among those of a much more normal physical habit and where the source of infection is frequently most difficult to locate. Observations of this character, however, prove nothing, of course. It is from the analysis of a given number of cases occurring under somewhat similar conditions, and among individuals of like hygienic and social relations, that statistics, to be of any value, must be drawn. Even so obtained statistical figures are very apt to be misleading, and are no doubt open to much just criticism on that score. I would not attempt to prove a theory by conclusions based upon an experience in 242 cases unless the results were very positive, but I would very much like to provoke discussion of a subject which cannot be devoid of interest in such a society as this Congress represents, and to stimulate further inquiry into a matter of such far-reaching importance. If I shall have accomplished this object I shall rest content with the assurance that the theory will take care of itself.

To proceed, then; the cases which I have utilised in this series have occurred in a community for the most part moderately well-to-do. Small tradesmen, mechanics, artisans, operatives in wholesome, well-lighted, clean and well-ventilated furniture factories, and small farmers. Nationality has been various. Next to American born, Dutch, German, Scandinavian and Irish predominated. Because of the comparatively recent development of the section of the country in which my observations have been made, and the more or less migratory habits of the first generation or so of foreigners in America, it has been the exception rather than the rule to be able to secure accurate data beyond the immediate parentage; but while it would be desirable to secure such data for purposes of demonstrating the transitory character of inherited immunity in tuberculosis, if such exists, for present requirements it is, I think, needless to do so.

The individuals comprising my series, by reason of their comparatively well-to-do condition and the customs prevailing in the locality, have none of them experienced the vicissitudes incident to life in the cheap tenement house districts of large cities. As a rule this class lives in small, compact but well-lighted and comparatively new frame houses, separated from each other by lawn spaces, and heated by stoves, or occasionally hot-air furnaces. In the course of inquiry, when phthisis was found in either or both parents, it was the rule, with very few exceptions, to find it to have been present during the early life of the case under observation, and to have been the cause of death. Frequently it could be traced back prior to the birth of my patient, and to have persisted with remissions in activity for a considerable time afterward; more particularly was this the case among women, where in several instances I have satisfied myself of its presence during most of the child-bearing period. Without exception these instances occurred among women of consumptive parentage. Of course, positive demonstration of the long existence of the disease in these cases was obviously impossible beyond the time of my own acquaintance with the case, and as scientific evidence, therefore, such citations are valueless.

Of my 242 cases, the parents, one or both, had phthisis in sixty instances, or 24.8 per cent., while the parents were non-phthisical in 182 instances, or 75.2 per cent. Of the sixty who had phthisical parents, the father was found to have been affected in thirty-one cases, or 1.28 per cent., the mother in twenty-nine cases, or 12 per cent., and both parents to have been phthisical in four instances, or 1.6 per cent.

(a) *New York Medical News*, December 3rd, 1898.

(b) "Heredity in Phthisis," *American Journal of Medical Sciences*, November, 1897.

It was more common in my experience to find a previous tuberculosis in a brother or sister or both than in the parents, and in such cases an almost perfect history of infection could be traced. It was often possible to designate the date of infection to within a few weeks, and in some instances to within even narrower limits, a point of some value in estimating the period of incubation, or studying that questionable quantity, the "period of latency."

Seventy-four of my cases, or 30.6 per cent., gave a history of previous tuberculosis in a brother, sister, or both, and it is a point of some interest that of these seventy-four only twenty-two were of phthisical parentage; furthermore, as will be recalled, there were sixty cases in which one or both parents were phthisical, and of these twenty-eight had brothers or sisters who were non-phthisical; or, to put it a little differently, out of sixty families with phthisis in one or both parents, there were twenty-eight instances of the disease affecting only one of several children. This does not, of course, imply that in the remaining thirty-two there was necessarily more than one child affected, for in many instances the patient was an only child.

It will further be seen that while twenty-two individuals having a phthisical parentage gave a history of previous tuberculosis in one or more brothers or sisters, there were fifty-two cases of non-phthisical parentage giving such a history.

These figures would certainly fail to show an hereditarily conferred predisposition to the disease, and if they have any value at all, it is on the side of a conferred immunity instead. Of the whole number, —242 cases—I can, at present, account for 235; of these 132 are living, and 103 have terminated fatally. Although it has a negative bearing upon the present inquiry, it may be of interest to note that in each group the percentage of phthisical parentage is the same. That is, of the 132 living, 26 per cent. had phthisical parents; and of the 103 dead, there was also 26 per cent. whose parents, one or both, had died of the disease.

The most interesting development in the course of this investigation has resulted from a study of the 103 fatal cases. As above suggested, 26 per cent., or twenty-seven cases, were found to be of phthisical parentage, while seventy-six had non-phthisical parents. My histories show that the average duration of the disease from its apparent incipency to the fatal termination was, in the incidence of the twenty-seven cases of tuberculous parentage, 4.01 years, while in that of the seventy-six cases of non-tuberculous parentage it was 2.93 years, a difference of more than a year in favour of those having a phthisical parentage.

Now it has been my experience that the development of phthisis in individuals living or having lived for any length of time with consumptive parents is more subtle and indeterminate as to commencement than is the case in the more robust offspring of non-consumptive families, where the onset of the disease is far more apt to be comparatively sudden, and consequently more easily determinable as to date of commencement. In this latter class the so-called "pre-tuberculous stage" has no existence as a rule, and the measurement of the duration of the disease is accordingly much simplified. This "pre-tuberculous stage" is, in reality, I am sure all will admit, a part of the life history of the disease and should be included with all subsequent stages of phthisis when estimating the duration of the disease in a given case; but because I desired to free my inquiry as far as possible from misleading results or error in judgment as to what was and what was not the early stage of tuberculosis, I have, in this series of observations, limited the definition of phthisis to a stage of the disease where it has been clearly demonstrable.

I have, therefore, a considerable leeway over and above the one year in favour of my cases with consumptive heredity, and had I included the "pre-tuberculous" stage in my estimates I am very certain that the difference in duration of the disease between the two classes would have been more marked than it is. I have, like many other observers, frequently demonstrated the presence of tubercle bacilli in the secretions of the air passages of healthy children and adults occupying apartments with consumptives, particularly consumptive parents, when subsequent events failed to show a development of tuberculosis from their presence. As an illustration: in a family consisting of a widow and four adult children, one of whom, a daughter, has been a consumptive for seven years (easily demonstrable during the whole of that time), the father had died after having had phthisis for upwards of twenty years. The consumptive daughter above referred to continued the local focus of infection after the death of the father, although to a less dangerous degree because of sanitary education. A few years ago one of the sons contracted typhoid fever, during the course of which the usual bronchitis developed. In the expectorated matter many tubercle bacilli were found during the course of the complication. Doubting the diagnosis of typhoid, I verified it by a positive Widal test and the diazo reaction in the urine. There was no pulmonary consolidation, and the case ran a typical course with good recovery and, to my surprise, has never shown the least evidence of tuberculosis since, although during several subsequent winter attacks of bronchial catarrh a search has been made for bacilli. I might add that in this family every one of the four children is apparently a classical subject for phthisis, with the long, shallow, and immobile chest, and the imperfect nutrition above remarked; yet, though having lived almost their entire lives in the house with a consumptive, only one has developed the disease, and that one presenting every evidence of being able to successfully resist a fatal termination for many years to come.

Vital statistics show a gradual declining death-rate from phthisis. This is doubtless in part the result of improved methods in restricting the spread of the disease, but, in view of many facts, is no doubt also due in part to one or both of two not unimportant factors—*i.e.*, natural selection and inherited immunity. If the conclusions reached by Otto Naegeli, based upon 500 autopsies made in the Pathological Institute of Zurich, on bodies of individuals dying of various diseases, shall be verified in other parts of the world, the question of inherited immunity must be acknowledged to play a very essential part in the decline in frequency and severity of phthisis. Naegeli found indubitable evidence of active or latent tuberculous lesions in 97 per cent. of all sections in individuals between eighteen and thirty years of age, and in 99 per cent. of those over thirty years of age. (a)

If it is true that all individuals reaching thirty years of age develop tuberculous lesions which are demonstrable post-mortem, the only explanation for the comparatively small percentage who die from phthisis lies in that of an inherited or acquired immunity.

Within the memory of men still living there was no phthisis among the Indian tribes roaming the high plateaux of Colorado, Arizona, and New Mexico. But a very few years after it became popular to send white consumptives to those regions as a therapeutic measure; the infection thus spread among the Indians gave rise to an almost epidemic form of phthisis of an unusually acute and fatal type. The same is true of the negroes of certain sections of the

(a) Virchow's Archives, May, 1900.

Southern States, whose heredity was entirely clean so far as tuberculosis is concerned, yet who succumbed in prodigious numbers as soon as the infection was brought them by the consumptive whites from the north, who, by reason of their greater immunity, often recovered by virtue of a climatic influence which, like that of Mentone, was insufficient to protect the unimmunised native.

The older writers, in speaking of the influence of family history in phthisis, often remarked upon the frequency with which the disease affecting the grandparents would skip one generation to reappear in the grandchildren. If there is truth in such a statement, it would seem plausible to attribute the phenomenon to an inherited immunity sufficient to protect the children, but not sufficiently permanent to protect the second generation. In my own experience I have not attempted records with this idea in view, and therefore have no facts to bear it out.

I must acknowledge one rather serious omission in the course of my investigations in the present series of cases. It was to a certain extent unavoidable, but in future inquiry along this line it seems to me most important that it be not again omitted if we are to arrive at any positive conclusions by such methods as I have employed. It lies in my failure to determine whether or not, when there was a consumptive parentage, the parent affected was tuberculous prior to the birth of the patient under consideration; for if such were not the case, and the patient became tuberculous only after the child was born, obviously any immunity to the disease which the child afterwards developed would be simply an acquired one; and if the child afterwards became phthisical, the disease in the parent would have no more bearing upon the case than had it occurred in a brother or sister. In such a case it would be quite proper to include it in the class of non-phthisical parentage, for the purposes of present study.

Briefly then, to summarise the results of observations in my series of cases, it will be remarked that:—

(a) Of 242 consecutive cases of phthisis, one in every four gave a history of phthisis in the parents.

(b) Nearly one in three gave a history of previous phthisis in a brother, sister, or both.

(c) More than two-thirds of those giving a history of previous phthisis in brother, sister, or both, had non-phthisical parents.

(d) As a rule, in the incidence of individuals of phthisical parentage afterwards developing phthisis, a much longer period was found to exist between the supposed exposure to infection and the subsequent appearance of the disease, than was the case in the incidence of those giving a non-phthisical heredity.

(e) Of 103 fatal cases of phthisis, the average length of life after development of the disease of those giving a history of phthisis in the parents, was to that of individuals of non-phthisical parentage approximately as 4 : 3.

So that, from a study of the foregoing series of cases, the following conclusions naturally follow:—

First, the percentage of consumptives having a tuberculous parentage is actually smaller than that having a non-tuberculous parentage, and much smaller than would be more than accounted for by the additional risk of infection to which the former class is subjected; and

Second, tuberculosis in the parents renders to no inconsiderable extent an immunity to the disease in the offspring, an immunity which, of course, is but relative, and not sufficiently protective, but still demonstrable, as is shown by increased resistance to the progress of the disease and increased tendency to recover among this class.

## EPILEPSY AND ITS PHENOMENA.

By GEORGE M. FOY, M.D., F.R.C.S.,

Surgeon to the Whitworth Hospital.

THE group of symptoms that the early Greek physicians named epilepsy remain after a long past centuries unexplained. And the disease remains an opprobrium to medicine and a mine of wealth to quacks.

From the great progress made in the study of cerebral pathology it might naturally be expected that more light would be thrown on this obscure disease, but so far we know little more than what we did when Moore's edition of Van Der Kolk's monograph was published in 1859. The study of the aetiology of the disease in Great Britain seems to have been neglected since Dr. Duckworth published his work on the efficacy of bromide of potassium in epilepsy and certain psychical affections in 1865.

Recently, on the Continent, there appears to be a revival of interest in the disease and its phenomena. To place a summary of some of the more interesting accounts that have been published is the object of this paper. M. Bourneville, at the recent meeting of alienists and neurologists of France, told of five cases of epilepsy which came under his notice in which the attack was followed by a rash which resembled purpura in some parts and in other parts took the form of rows of flea bites.

The face and neck were attacked in all of them, and in one case the eruption spread all over the body.

Except for the epilepsy, all the patients enjoyed good health and were not at all anæmic. He drew attention to the similarity of these rashes, which remained but a few hours, to the stigmata, which are permanent, of the hysterical.

M. Crocq told of a patient sixty-five years old, who, after each epileptic attack, suffered from a purpuric rash on the face and from hæmaturia. He placed the patient on moderate doses of tincture of the perchloride of iron—the hæmaturia ceased, and never afterwards had he the purpuric rash. M. Doutrebente drew attention to the association of epilepsy and hæmophilia—a patient of his died from bleeding due to the extraction of a tooth. M. Bourneville mentioned that none of his five cases suffered from hæmophilia.

In this connection the experiments of MM. Dide and Sacquepin are interesting. They drew off some of the cerebro-spinal fluid of epileptics immediately after an attack and injected it into guinea-pigs. The first effect of the injection was to cause the animals to fall forward, to become stupefied, and to have convulsive movements. After the attacks the cerebro-spinal fluid when injected in doses of from four to one hundred cubic centimetres produced violent general convulsions. A dose of half a cubic centimetre injected produced death, the fatal result occurring from a few minutes to half-an-hour after the injection. In every case death was preceded by epileptiform and tetanoid convulsions.

## PRÆPHTHISIS AND PHTHISIS IN RELATION TO CONSTITUTION.

By WILLIAM H. PEARSE, M.D.Ed.,

Senior Physician, Plymouth Public Dispensary.

IN February last I was favoured with space in THE MEDICAL PRESS AND CIRCULAR for a paper on the "Correlations of Phthisis." Since then I have gone through my case-book for the last two-and-a-half years, and have cast into the following Table an abstract of all the cases of præphthisis and phthisis which have presented.

In my February paper I viewed the varied deviations of function and structure of præphthisis and phthisis

in their relation to heredity, and to the epi-meso- and hypo-blast. I also indicated the principle of Atavism, both in relation to function and structure; but, further, I especially pointed to the great principle of Alternation, i.e., that deviations of function in one generation had biological and essential continuity with deviations of structure in other generations and *vice versa*, and, yet more, that such fundamental deviations or conditions, in other individuals and generations, were expressed or shown by weak molecular bonds of the bioplasm of one—usually one—or both lung apices, and that thus the lung apex partially dying too early in the life of the individual, gave a nidus for the stronger molecular attractions of the unicelled bacillus. The greater basis of phthisis was thus seen to be in the constitution. My cases carried the mind far more toward the great laws of the biological evolution than toward bacilli as measuring the fuller Form of phthisis. (a)

Having in February last pretty fully enlarged on such facts and hypotheses, I shall not go over the same ground now, but simply record in the Table the results of two-and-a-half years' observation; following the Table I shall add a few illustrative cases, and the "illuminating Ideas" (Coleridge) which flow from them.

The Table shows in the two groups of præphthisis and phthisis a great similarity in the deviations, both of function and structure; a Continuity is seen in the two groups; prior to the final bacillary development in the cases of phthisis, the two groups are indistinguishable; in other words, phthisis has a long pre-stage of deflected function and structure; we may not be able to state this orderly continuity and pre-stage with the precision of a syllogism or a sum, but it is not the less clear if we have any approach to a justly wide Method of viewing the biological evolution. The Table also shows that the continuity of præphthisis and phthisis has its roots far back into heredity.

*Function.*—The most striking condition of the early stage of phthisis and præphthisis is the sensation of weakness. A great number of patients, both præphthisical and in phthisis, have told me that the first thing they found wrong was an extreme sensation of weakness; in many such præphthisical cases there was no wasting, but the feeling was present in fine young men and women, and existent often for a year or two prior to any other sign or symptom of disease. It is but to deceive ourselves with "words," (b) to rest for explanation of this phenomenon in such expressions as "exhaustion of the nervous system," or in "muscular weakness"; the conditions of such "weakness" are general, in defective molecular modes, and deficient potential vital "energy" of bioplasm, conditions too subtle for any of our present powers of analysis.

The same class of cases will often say that for years they have suffered from sensation of "coldness," especially from cold feet at night. The explanation must be sought in the same general deficient "potential" which is the basis of the "weakness." "Heats" and sweating were complained of far less often than was "coldness."

Præphthisis correlates with much disturbance of the sexual system, of which amenorrhœa is the most frequent phenomenon, sometimes, but rarely, total amenorrhœa; on the other hand, menorrhagia sometimes exists. But both these conditions so often exist where there is no tendency to phthisis, that they must not be looked on as "causes" of phthisis. At the same time, observation of Nature shows that in those who will eventually pass into phthisis, there is a deficient or disturbed correlation of the great fundamental sexual origins; even barrenness has been seen to have correlation with, and to be atavic to, those conditions of bioplasm which have passed into phthisis.

(a) The word *Form* is preferable to the word *Law*; Bacon, following Plato, makes the word *Form* to imply all the contained processes of Matter and Energy, going along with the inspiring Ideas which should arise from a view of facts, "That forms were the true objects of knowledge." Coleridge beautifully expounds the same philosophy in his treatise on "Method."

(b) Bacon says, "... yet certain it is, that words, as a Tartar bow, do shoot back upon the understanding of the wisest, and mightily entangle and pervert the judgment."

When a refined, spiritually-minded, poetic girl of from sixteen to eighteen, and who has a fine type of physical formation, is brought for amenorrhœa, it is a miserable conception of biology and pathology to confine our mental view to the sexual organs. The sexual organs are but differentiations of a universal energy of bioplasm. We have to deal, in such a case, with modes or defects of bioplasm of infinite delicacy, defects which are in continuity with that failure in energy in the attraction of the molecular bonds of lung-apex bioplasm which in a few years may give nidus for the molecular attractions of the unicelled bacillus. The amenorrhœa of the young girl of the type I have depicted, and her future phthisis, are parts of a progress of universal laws acting in orderly continuity.

Contrast the above-typed girl with the rapidly developed, plump, fair, and somewhat lethargic, young country girl of the S.W. counties, who has amenorrhœa and is a little chlorotic, but who will balance the just order of evolution in a year or two, and live to bear and suckle from fifteen to twenty children, and we shall see at once how deep down in the constitution are the paths to phthisis in the former and how absent they are in the latter; the complexity—yet so orderly—of the involvements are not yet unravelled, but we must justly learn by observation and analogy long before we have mastered the subtle bio-chemistry and bio physics of the different types. It is sufficient here for me to point to the "constitution" of a type of young woman who, now in amenorrhœa, will, in absolute continuity, pass in future years into phthisis.

Trousseau long ago pointed out the sometimes danger of giving Iron, and of forcing the monthly function, in those who tended to phthisis. In the delicate-typed class of girls to whom I have referred, the absence of the monthly function seems to be a normal or natural and harmonic condition, justly correlating with the whole system, and it may be most dangerous to hastily disturb the balance of the complex system. In modern theory, we may thus aid to create a nidus for the bacillus in the lung apex. The monthly period should be re-established by the slow and harmonic development of the whole system. I make these remarks because chemists tell me that they sell Bland's pills for the gross to young girls—and old—under the hope or fancy that the complexion is improved by their use.

The basis of the future phthisis may often be seen years prior to the bacillary stage in a prevailing poorness of appetite, and especially in a repulsion to fat, excepting butter, which holds an organic acid in its constitution. Young people who will repel every particle of fat meat, will eat buturic-acid-butter with avidity; often, too, such patients will readily eat the fat of smoked or salted meat. I have known many who, repelling all other fat of meats, would heartily eat the fat of roast pork. Such facts point to some "deep, hidden law" in the bio-chemistry of the cell and system.

In a very great series of cases I have known the præphthisical and phthisical possessed of a passion for onions, raw or cooked; hundreds of young, delicate præphthisical patients have told me of their passion for onions, and that no food agreed with them so well, or seemed to give them so much strength. Is such result due to the energy of the allyl molecule? Such facts put us on the path leading to foundations in pathology.

Similarly, though in a less degree, there is often in the præphthisical a great desire for pickles. I always encourage such longings, as promoters of appetite, purifiers of the *primæ viæ*, and, it may be, just balancers of metabolic processes. The Native of India has a passion for limejuice, tamarind and other fruits; by them his anæmia, night blindness, proneness to vast ulceration of the intestinal mucous membrane and skin are prevented and relieved.

Both with the Native of India and the præphthisical European, the benefits from such kinds of food are not to be explained by any present chemistry; such longings are the absolute expressions of orderly laws, as much so as when the stone falls, or the needle points to

the N. The full Form or nature of phtthisis is involved in these allyl and other longings.

*Structural.*—But the profound nature or Form of phtthisis is not only seen in the long preceding deviation of varied functions, but also in marked deviations of structure. As I have on former occasions pretty fully depicted the structural changes of the præphtthisical and phtthisical (a), I shall now confine myself to a mere reference to the facts of the Table, nor shall I repeat an attempt to correlate such structural deviations to the blastoderm and its layers.

Following the order of the Table, in the præphtthisical there is often marked deviation in the hands; the hands are often unduly large, long, and cold; now and then the hands may be unduly small; the clavicles are often unduly big; they too, now and then are small and fine. I have seen young men, otherwise fully grown, in whom the entire thorax had almost ceased to develop during many years. In other cases, children of sixteen had hardly grown since ten or twelve years of age.

But more frequent than any of the above deviations are those of the terminal cartilages of the nose. Unduly large terminal cartilages which are non-symmetrical on the two sides and non-mesial, and which tend to point laterally, semi-truncated *a/s nari*, have a very marked correlation to phtthisis. These structural variations are often atavic and alternate with phtthisis.

L. B., f., æt. 17, came for "weakness." No physical signs in chest. Nose to left; terminal cartilages big and unsymmetrical; nails rounded; eyebrows big. Father and brother died of phtthisis.

S. F., f., æt. 35, came for "weakness." No physical signs. Nails almond-shaped; index nails most so. Terminal cartilages of nose very pointed laterally. Her father, mother, and brother died of phtthisis; also her mother's sister and brother.

J. S., f., æt. 27, came for "weakness" and cough; suffered extreme sensation of coldness; no appetite; she had phtthisis of right apex; nose sharp at end and pinched; slight median terminal sulcus; one brother died of phtthisis.

*Skin system.*—I am carried far away from some recent utterances: "Phtthisis . . . is the work of a microbe, the tubercle bacillus discovered by Koch," by the great stream of præphtthisical and phtthisical cases, of which the foregoing remarks and cases are but a tiny part; nor less enlarging to our view of phtthisis, is the study of its correlated skin deviations. Nails cupped, transversely ridged, exquisitely fine, friable, &c., each may correlate with phtthisis, sometimes in the same individual, but more often as alternate and atavic phenomena. Heavy eyebrows which tend to meet in the centre, coarse and abundant hair, ears which stand out at a big angle, conditions of teeth, such as translucent enamel, small upper lateral incisors, congenital absence of the upper lateral incisors, all these correlate with phtthisis.

I would illustrate these præconditions, these wide correlated formative stages of the soil, in which the bacillus can flourish, by a great array of recorded cases, but I hope that I have said enough to make clear the correlatability and continuity of Function and Structure, and yet further, their atavism and alternation, extending sometimes over many generations.

*Heredity.*—Though at the same time a constitutional base was admitted, the world has lately been authoritatively told that "phtthisis is not an inherited vice in the constitution. . ." This dictum recalls Bacon's words, "It is almost necessary in all controversies and disputations to imitate the wisdom of the mathematicians in setting down in the very beginning the definition of our words and terms." In this instance we should have to define the word "phtthisis."

If we assert that phtthisis "is the work of a microbe, the tubercle bacillus discovered by Koch," and confine our view to that final stage only; or if we are enchained by nosological definitions, that "phtthisis is a disease of the lungs," we may fairly assert that "phtthisis is not an inherited vice." But the great stream of præphtthisical and phtthisical cases which passes before me has shown that the final lung bacillary invasion is but a very minor

part of the full Form of phtthisis; if we would rise to a just conception of phtthisis we must use the Method of Evolution and Continuity, in general, as applied to the organic kingdom; our definition of phtthisis then would embrace the modes of the ovum and sperm cells, the blastoderm and its layers; and yet more, phtthisis involves the differentiations of those layers as eventually passing both to function and structure. Why should the physician and pathologist be limited and confined to a verbal, nosological, or bacillary foundation or measure of disease, whilst the trend of all other organic and biological science is toward common forms, general alliances, and unity of law and order. Phtthisis thus should be viewed from its primary roots and origins up through all its transitional stages; and in this Method it will be found that Heredity holds an ever present influence.

*Slow Evolution.*—With inherited tendency, the potential energy of the lung apices lasts on variously to adult age; then expiring, the bacillary bioplasmic attractions overpower those of the lung. It is a common experience that even then some patients will last for many years, so nearly perfect are the vital bonds and energy of lung bioplasm; in other cases the lung is destroyed in a few months.

Parallel phenomena are seen in a family where several die of phtthisis, and one escapes; no other explanation seems possible, but that that individual who escapes has received at birth a higher potential in the lung apex bioplasm. I think that we should carry into our view of disease the largest general views of biology, in its wide correlations and great periods of time, which we, in this day, ever apply to paleontology, geology, physics, and to all other orderly and naturally evolving phenomena of Nature. To cite one illustrative case. S. E., f., æt. 38, has come to me every year for twelve years past, sometimes for "weakness," at other times for varied neuralgic pains, at others for "indigestion"; she is not wasted. I have never found any physical signs in the lungs. The nose has big terminal cartilages, the nails are rather rounded, the right index nail cupped, the right middle nail has transverse ridges. She had a child twelve years ago, but has since been barren. Her father and two of her brothers died of phtthisis. From a wide biological view, I am compelled to view this woman's deviations of structure, and especially her deviations of function, as in absolute and orderly continuity with the phtthisis of her father and brothers; she has been all these years in hovering unstable biochemical equilibrium. But how exquisitely delicate in difference must be the modes and bonds of her lung bioplasm, which save her from those losses of energy, which led to a fatal result in her father and brothers. I am compelled to fall somewhat into the Method of the naturalist who is studying variation in species—present or paleontological—when I am in presence of such instances of "variation" and continuity in disease.

*Bacilli.*—The experienced eye can, in a large proportion of cases, predicate of certain individuals, that at early ages they will pass into phtthisis; with no less certainty can we say that individuals of another type will never pass into phtthisis.

The types of the præphtthisical and phtthisical are approximately given in the Table.

One may justly hold the hypothesis that the bioplasm of an organic cell can be resolved into the substituted ammonia groups of alkaloids, &c., down to more stable elementary bodies—carbon dioxide, urea, ammonia, water, &c., by and through the inherent bio-chemical dynamics of its contents; but it is no less true that parallel changes are often set agoing by the molecular motions of unicelled organisms, yeasts, bacilli, &c.

Thus theory and experience both accord with the great place which bacilli hold in the last stages of the lung destruction of phtthisis.

But the pollen falls in vain on the stigma, except at certain recurrent harmonic modes or molecular motions of the stigma's protoplasm, and so throughout the vegetable and animal kingdoms, the molecular activities of the sperm cells are in vain, except in presence of certain harmonic modes and motions of receptivity and absorption.

PHTHISIS AND PRÆPHTHISIS AND THEIR CORRELATIONS.

AVERAGE AGE.	SEX.		CORRELATIONS																																			
	M.	F.	Hands.	Clavicles.	Nose.	Terminal Cartilages of Nose.	Skeleton.	Nails.	Hair.	Kybrows.	Ears.	Teeth.	Amenorrhæa.	Total Amenorrhæa.	Barren.	Hæmoptysis.	Malarial Fever.	Indigestion.	Costive.	Anorexia.	Likes Smoked Food.	Likes Onions.	Likes Salted Food.	Likes Pickles.	Likes Pork.	Likes Cheese.	Weakness.	Wasted.	Coldness.	Diabetes.	Eczema.	Neuritis.						
32	13	14	5	2	16	13	3	15	3	5	2	6	5	2	4	1	1	3	3	1	2	13	2	3	4	2	3	8	2	1	1	1	1	1				
27	8	7	10	2	21	20	2	23	2	6	2	10	10	5	4	4	1	3	2	3	2	13	2	2	4	3	5	13	2	1	1	1	1	1	1			
21	13	14	5	2	16	13	3	15	3	5	2	6	5	2	4	1	1	3	3	1	2	13	2	3	4	2	3	8	2	1	1	1	1	1	1	1		
23	8	7	10	2	21	20	2	23	2	6	2	10	10	5	4	4	1	3	2	3	2	13	2	3	4	3	5	13	2	1	1	1	1	1	1	1	1	
23	8	7	10	2	21	20	2	23	2	6	2	10	10	5	4	4	1	3	2	3	2	13	2	3	4	3	5	13	2	1	1	1	1	1	1	1	1	1

The facts of germination by fission do not militate against such theory, because the creative power of sperm and ova cells are but differentiations of a universal energy and motion existent, more or less, in every cell of the organism.

Darwin says:—"All the forms of reproduction graduate into each other, and agree in their product, for it is impossible to distinguish between organisms produced by buds from self-division or from fertilised germs."

Similarly, the tubercle bacillus falls in vain on the lung bioplasm of certain types of men and women; hypothetically, we may assert that the lung molecular bonds are stronger than are those of the uncalled tubercle bacillus.

The Table shows the congeries and correlations of functions and structure, extending often back through many generations, of those in whom the molecular bonds of the bioplasm of the lung apices cease their powers too early in the life of the general organism of the individual.

This constitutional mode or state, correlating with the most fundamental laws of the biological evolution, seems to loom up as the major Form of phthisis.

In view of the various phenomena of function and structure, and of their wondrous commingling and correlations the words of Goethe arise—

"Thus the whole of the throng points to deep-hidden law,  
Points at a sacred riddle."

*Treatment.*—Treatment should in the main be prevention; recognising that a child is not of robust type we apply the tonic regimen—exercise, pure outer air, in all its known and unknown mighty potentialities of sunshine, light, motion, chemical action, electric energy, &c. The atmosphere is truly cosmic in its correlations to life and health; by exercise in the open air we use the greatest fulness of all the energies which make for and are true parts of life. Pure air in the day and the active metabolism which exercise produces; pure air at night, but with judicious warmth. Such physical energies should be used in no excess, but in harmony with the capacity of the system to enjoy them, for different individuals need them in different degrees. Moderate, but continuous through years, should be the method of the tonic regimen, in harmony with the processes of the growth and evolution of the organism. We find that those who are hovering on the brink of phthisis get a great restoration by a month or two of wandering in the summer on Dartmoor. The body, mind, and feelings are all greatly influenced for good; I conceive that the restoration of a bright and happy mental state is of supreme importance in warding off phthisis. My impression is, that it is better to send an early phthisical case to wander on the moors, and to be there mentally interested in its geology, botany, archæology, and scenery, and to be absorbing its full stimulating physical and psychical influences, than to send such a case to a "home." I should say to the patient—"Go and enjoy yourself, 'eat drink, and be merry,' and don't take a clinical thermometer with you!" When I recall remembrance of the great stream of phthisis and præphthisis which I have seen during the past twenty-five years I am compelled to accept the words which Dr. Baly used after his grand review of the conditions and phenomena of cholera, as no less true in reference to phthisis:—"Moreover, no *simple* theory (the italics are Baly's) that has yet been proposed, will account for all the facts in the history of epidemics of cholera."

**Germany.**

[FROM OUR OWN CORRESPONDENT.]

BERLIN, August 31st, 1901.

**THE SIGNIFICANCE OF THE SALTS AS REGARDS THE BACTERIAL ACTION OF SERUM.**

The *Zeitsch. f. Hygiene*, &c., has an article on this subject by Dr. v. Lingelsheim, from the investigations of

the writer it appears impossible that the effect of serum can depend on the osmotic process. The osmotic pressure is far too small to effect any considerable diminution of germs. In its qualitative aspect the serum action in the solution of cholera bacilli in rat serum is quite different from that occasioned by purely osmotic powers. All the conditions observed favoured the view that the bactericide power depended on special chemical substances nearly allied to the known ferments. One objection created some difficulty in an explanation, and this consisted in the fact already communicated by Behring that anthrax bacilli dried on silk threads grew and developed apparently without hindrance in active serum. A similar behaviour has been observed as regards bacilli contained in pledgets of lint, and the hypothesis has been brought forward that the serum cannot come into contact with the bacilli in the dried material and that the bacilli in the capillary spaces are less acted upon by the alexines. But all this cannot explain the fact that such bacilli grow in the presence of bactericide material. Experiments have led the writer to a more comprehensive explanation. The hypothesis of Fischer that the action of immune serum is attributable to an increase in the salts is in distinct contradiction to the elementary facts of immunity. The existence of bactericide ferment like active bodies in extra-vascular blood or serum can no longer be denied. Their relation to congenital natural immunity is still unknown for the reason that it is not known whether this material in its active state is contained in the living circulating fluids. The fact that they are in combination with certain specific immune bodies that come into action says nothing as to their behaviour with these bodies. Natural immunity no doubt depends on quite a series of components which may vary from case to case.

The *Archiv. f. Gyn.*, Bd. 63, contains an article by Prof. Kroenig on

#### THE PROGNOSIS OF ASCENDED GONORRHOEA IN WOMEN.

On the basis of his own observations the Professor comes to the conclusion that the prognosis of ascended gonorrhœa in the female is not at all unfavourable. The greater part of his thirty-eight cases of gonorrhœal adnexa disease recovered in a not lengthy period so far that pain no longer rendered them unfit for work. The treatment in the klinik was as follows:—If pain was great along with fever purgatives were given, generally saline, and ice bags were placed on the abdomen. No treatment was carried out per vaginam. After evacuation from the bowels, which was carried out to four to six stools per diem, the fever subsided in every case. With rest in bed the severe pains in most cases subsided. As soon as the symptoms subsided ichthyol tampons were inserted in the vagina, alternating with douching with hot water. In case of excessive hæmorrhage stypticine in three daily doses of 0.05 grm. was ordered, whereupon as a rule the hæmorrhage ceased. During treatment care was taken to avoid firm stools, fluid diet only was given. On discharge from hospital complete recovery had not by any means taken place, but the patients were quite capable of attending to their domestic duties. When the patients were treated as out-patients the treatment was the same, with the difference, however, that the measures could not be carried out so strictly. Want of the needful rest in bed was one cause of failure,

and also continued cohabitation on the part of the husband, even when strictly forbidden. This was a more disturbing factor than even continuance at work. But as a rule the polyclinic treatment was not longer than a few weeks, possibly partly for the reason that work at home prevented their attendance as long as was desirable.

Dr. Th. Neubiuger, Frankfort, has an article in the *D. Med. Woch.* on

#### THE RELATION BETWEEN SCLEROSIS OF THE CORONARY ARTERIES AND DISEASE OF THE CARDIAC MUSCULATURE.

His observations have led him to the view that the disease of the coronary arteries and the disease of the cardiac muscle caused by it develop in a certain and fixed manner, that they form a distinct clinical entity, and that the disease called angina pectoris is only a part of the complex of symptoms. The disease attacks men more than women, as a rule those of higher ages, and leads after months or years not unfrequently to sudden death. It may at times come to an apparent standstill, or recovery may be simulated.

The author distinguishes three stages in the development of the disease. The first he designates disturbance of sensibility, the second disturbance of motility, and the third disturbance of nutrition. In the first stage the patient complains of the well-known pains that cease on standing still or resting. As the disease advances the pain comes on on the least exertion or even when at rest, sleep is disturbed, and some patients complain of giddiness. After a varying length of time the second stage appears. The working power of the heart diminishes, the patient is easily tired, the breath is short, the pulse becomes small, empty and quick or abnormally slow. Percussion and auscultation reveal nothing abnormal, if there has been no previous valvular disease. This stage is not of long duration, and the third soon supervenes, that of disturbance of nutrition. The breath is short and superficial, the pains are more frequent and severe, the chest is affected, and thin frothy sputum is brought up, sometimes tinged with blood. The organic changes in the coronary arteries and in the fibres of the heart are so great that the heart ruptures. It rarely happens that patients in the third stage, after violent attacks, maintain their ground.

The treatment is that of heart diseases generally. Mental and bodily rest are essential. Nitrite of amyl gives passing relief, small subcutaneous doses of morphia are useful, and also the hypodermic use of caffein, sod. salicylate is to be commended. In case of lung stasis, digitalis given for three or four days every two or three weeks is useful. Dropsy may be suitably treated by diuretin. Mounting steps is injurious. Residence in high altitudes or on the sea is less to be feared. Syphilis and free living have no influence on the origination of the disease. Neither does valvular disease predispose to it. On the other hand, hereditary predisposition has a powerful influence. Among the 143 cases treated by the author, thirty of these were blood relations.

#### DEATH OF SURGEON-GENERAL VON COLER.

Dr. von Coler, the head of the Army Medical Corps, died of cancer on Monday week: he was born in 1831, and studied medicine at the Army Medical Academy in Berlin. He began his military career in 1856 as a



volunteer surgeon in the Dragoon Guards, and was appointed staff surgeon seven years later. He took part in the campaigns of 1864, 1866, and 1870-71, and distinguished himself so greatly during the operations that he was appointed as one of the first members of the medical section of the War Office, which was established after the end of the Austrian war. He played an important part in the reform of the Army Medical Corps, of the field and other military hospitals and the general sanitary condition of the army, and was subsequently appointed head of the Army Medical Corps.

## Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, August 31st, 1901.

### NARCOSIS, OR ANÆSTHESIA.

The great ambition of the surgeon in modern times is to discover a narcotic or anæsthetic that will prove efficient and safe. To operate is now an easy and familiar art, but the performance without pain and yet secure safety is not quite so easy. Nothing in our armamentarium can surpass chloroform for efficiency, but its fatalities are on the increase. Schneiderlin proposed a form of narcosis by means of skopolamin hydrobrom with morphia, which he seems to have practised with considerable success. Korff now comes forward with a modification of this treatment and combines chloroform. His mode of procedure is first to clear the prima via. About seven in the morning of operation he orders a light breakfast of some fluid, at 8.45 he gives 0.004 gramme of skopolamin hydrobrom, with 0.01 gramme of morphia hydrochlorate subcutaneously; at 10.30, a second similar dose. If by this time the external reflex is not quite abolished a third dose may be given according to individuality an hour later, or about 12 o'clock. An hour after the last dose a few drops of chloroform are placed on an inhaler and administered in the usual way; only  $\frac{1}{10}$  or possibly  $\frac{1}{4}$  of the usual quantity is required to accomplish perfect anæsthesia. In eighty operations under this anæsthetic he had performed amputations, extirpation of mammary carcinoma with removal of glands from the axilla, gastrostomy, carcinoma of bowel, &c. The results were of the happiest kind, the patient resting quiet and calm after the operation.

### A CRYSTALLINE IMMUNISING PRODUCT.

Bordet was the first to draw attention to the immunising power of soluble albumen taken from an animal that had been previously immunised with blood serum, and that a precipitate could be obtained from the same blood by adding the same serum. In pursuing this experiment further Buchner and Jeret have found that a pure peptone, or the blood of the reindeer, can be acted on in a similar manner by the serum of the guinea-pig, which produces a crystalline precipitate with the property of a globulite. This globulite has an irregular round bean or kidney-like shaped crystal, strongly refracting light, and ranging in size from one to ten  $\mu$  in diameter, and very resistant to chemical agents. Its organic nature may be proved by origin, its behaviour with heat, and colouring with iodine.

### CHOREA AND ARSENIC.

Arsenic was recommended in cases of chorea by Comby

in such large doses that fatal results were often attributed to the drug and not to the disease. Although the drug has decided power in allaying the reflex action, it fell into disuse for a long time, till Bechterew awakened the old method by commencing with small doses and gradually increasing the quantity till very large doses can be taken with immunity, but never reaching a dangerous dose as Comby preached.

Bechterew also favours the use of bromide of potassium along with the arsenic, while salicylate of soda and cardiacs are also combined in many cases. In addition to these internal remedies he recommends hydropathic treatment, quiet in bed, and plenty of fresh air. Two weeks he considers the average time of treatment, although severe cases may be a month before convalescence sets in.

### MULTIPLE SCLEROSIS.

Gaup is in favour of injury being the real origin of this morbid transition. Anything that will injure the general system will affect the organism, disturb the sleep, and act as the initial factor in the nerve disturbance. Multiple sclerosis may be diagnosed if after an accident no cerebral or spinal effects seem to persist or remain prominent, but on the contrary a slow progressive development of the characteristic symptoms appears: For example a man falls five metres, and becomes unconscious, with pain afterwards in the occiput, more particularly on the right side, associated with the right foot, this being accompanied by vomiting. After this there is general pain, vertigo, with an easily tired feeling, an unsteady gait, weakness in the right leg, muscles of the neck, and a stiff feeling in the fingers. Next follow changes in the eye, the temporal papilla quadrant becomes white, the range of vision is narrowed, red and green are confused for one colour in the left eye, while there is increased tendon reflex and lowered cutaneous reflex. Along with these there is paresis of the muscles of the back and abdomen, and muscular groups of the lower extremities without spasms, although there may be distinct ataxia present. The paresis of the left side is usually greater than that of the right. The Romberg symptom is slight at first due to the paresis, while the ataxia and vertigo go on increasing.

Gaup considers the sclerosis commences first in the cerebellum from the tonus regulating function of the brain being early affected.

## Special Articles.

### DISINFECTING STATIONS AND TEMPORARY ISOLATION HOUSES.

THE threatened invasion of Europe by the plague is keeping the Continental medical world on the alert. The need of preventive measures is being pushed before Governments and Legislatures, while administrative sanitarians are doing their best to perfect national sanitary defences. The necessity for providing means to insure disinfection of houses in which zymotic diseases had occurred has long been recognised. Paris possesses a decidedly efficient Services des Etuves Municipales, which is divided into two branches (1) Stations where bedding, household linen, clothes, &c., are disinfected by steam under pressure; and (2) domiciliary disinfection of walls, floors, furniture, &c., by means of a spray of corrosive sublimate at a strength of one in the

thousand. At Berlin, house disinfection following many diseases is compulsory, and is carried out by the municipality. The means employed are: For bedding, household linen, and wearing apparel, steam at 212° F., under pressure; for the houses, rubbing down the walls with bread cut in large lumps, followed by a thorough sprinkling of carbolic acid at two and a-half to five in the hundred. Other municipalities carry out similar duties more or less systematically and stringently. But it was felt in some quarters that these precautions were not sufficient, as enormous difficulties arose in practice where poor folks lived crowded together in one or two rooms. Hamburg, we believe, was one of the first Continental cities to organise a disinfection and temporary isolation station on a large scale. The institution is meant both for townspeople and the seafaring classes. The whole station is arranged on the dual system: entrance section for suspected goods and individuals, and exit for the purified. In this institution poor people are received, their property disinfected, they themselves brought under the beneficial influence of baths, &c. While they are kept under observation for a day or two, their rooms are thoroughly disinfected and cleansed. In this way efficiency is attained with the least possible hardship to the people, and really at very little expense to the municipality. This system has been boldly adopted in Belgium, and Dr. Alfred Fillasier, of the Préfecture de la Seine, has written a most interesting pamphlet on "Les 'Postes Sanitaires' dans les Grandes Villes," in which he gives valuable details of this branch of municipal sanitary work. At Brussels, the "Poste Sanitaire" has been at work for some years, doing excellent service. The building consists of a ground floor and first floor. On the ground floor are the rooms for the attendants, w.c.'s and spray baths. On the first floor are found a dormitory with nine beds, lavatory, bath-room, and refectory. Persons brought to the station are conducted direct to the spray baths, and then to the dormitory. Meanwhile the clothes are disinfected, and their homes cleansed. Usually the next morning they are given a light breakfast, their clean clothes are returned, and they are at liberty to return home. The whole cost amounts to about 1s. 8d. per head per night. Antwerp possesses two similar stations, capable of receiving respectively seventeen and eighteen persons. The cost of the two stations for 1900 was under £300, including dinner, supper, and breakfast for each inmate. It is found that by these means domiciliary disinfection can be effectively carried out, at little trouble to those most interested, while people who could with difficulty be reached otherwise are brought under the control of the sanitary authorities. Thus greater efficiency is attained than if merely the sufferer from an infectious disease was treated at an isolation hospital. The system is so simple and free from hardships that persons of the poorer classes quickly recognise its value, and voluntarily submit to the sanitary authorities, as they see that by following this course they obtain greater personal security, and are not inconvenienced by the house-cleansing processes. M. Fillasier is anxious that "Postes Sanitaires" should be established at Paris, in order to complete the present disinfecting service the work of which, although carried out as systematically as possible, is often rendered nugatory

to the difficulty of cleansing a single room occupied by a whole family, who have nowhere else to go. It is claimed that such a step will be absolutely necessary if the recommendations of the Commission de la Tuberculose are adopted, in order to insure thorough disinfection of rooms and persons brought under the deleterious influence of consumptive patients. Such stations are also invaluable at maritime ports, as they are so easily managed at very little expense, and do not involve the hardships connected with isolation hospitals. It is also to be observed that municipal "Postes Sanitaires" as here described would greatly lighten the work of Port-sanitary authorities, and being under municipal supervision and frequented by ratepayers would not be so liable to the slovenly, and too frequently most insanitary, management of purely quarantine stations. Undoubtedly these "Postes Sanitaires" are admirable adjuncts to isolation hospitals, completing the sanitary circle at little cost, and at practically no inconvenience to the working classes, who are mostly concerned in the matter. Indeed, if all circumstances are borne in mind, the system means economy to municipalities and to citizens, as the figures and statistics in M. Fillasier's pamphlet so clearly demonstrate.

#### HEALTH MATTERS IN SALFORD.—ANTI-DIPHTHERITIC SERUM.

THE Annual Report of the Hospital Department of the County Borough of Salford for the year 1900 contains references to many points of general interest concerning the public health.

Like all such reports, statistics in tabular and schematic form occupy a considerable portion of the book.

The great question of "return" cases is touched on, and the erection of convalescent pavilions is considered to add "another line of defence to those already existing between the public and the recurrence of infectious disease, more particularly because more necessary in scarlet fever." It has been pointed out elsewhere that convalescent pavilions probably lessen also the liability to early second attacks in the same individual. The medical superintendent, with admirable foresight, and, we think, with great justice, warns his readers against expecting that even with the most carefully arranged system of convalescent pavilions, cases, apparently "return," will cease entirely to appear.

The infectious diseases principally dealt with in the report are scarlet fever, enteric, and diphtheria.

Of scarlet fever cases 1,328 were admitted with a mortality of 7.5 per cent. The average number of days spent by each patient in hospital was 44.7. This period will appear to some readers a somewhat short average time for isolation. The number of cases of enteric admitted were 216, and the percentage mortality was 25.0. The daily average number of days spent by each patient in hospital was 29.6. This will also appear to some remarkably short, especially in view of the fact that the percentage mortality was as high as 24.2. Of course, it must not be forgotten in this connection that many of the deaths among enteric cases in hospital occur shortly after admission.

The number of cases of diphtheria was 294, the percentage mortality was 24.2, the daily average number of days spent by each patient in hospital was 19.9.

The medical superintendent says:—"I have no hesitation in asserting that such heart failures, or any of the sequelæ of diphtheria, are from my experience unaffected by the use of anti-diphtheria serum." This opinion is the result of his experience of previous years as well as that of last year. He urges the importance of exhibiting this remedy as early as possible in doubtful cases as well as in certain cases of diphtheria. We may point out that in Liverpool the five fever hospitals in the city are used as depôts from which practitioners may obtain gratis a supply of serum at any time, day or night, for the use of poor patients.

"During the past twenty years," the report says, "only three members of the hospital staff have contracted diphtheria, while twenty-three contracted enteric. As no mention is made of it, it must be assumed that anti-diphtheria serum was not used as a prophylactic measure.

It seems a pity that the bacteriological work, for the efficient performance of which the superintendent acknowledges his indebtedness to his assistant medical officer, Dr. Pringle, has not been given more space in the report. More particularly would one appreciate bacteriological details in connection with the report on the use of anti-diphtheria serum in the treatment of "secondary malignant sore throat" among the scarlatina patients, which is said to have been attended by very marked and gratifying results. In fact, not one death has followed this "complication." It is not noted whether bacteriological examination of the throat is made preparatory to the patient's discharge from hospital. It would be interesting if in future reports a table were included showing the ratio of cases admitted to the total notified.

The medical superintendent, Dr. J. W. Mullen, is to be congratulated on his report; the arrangement of the matter makes reference easy and rapid.

## The Operating Theatres.

### GUY'S HOSPITAL.

**NEPHRECTOMY.**—Mr. ABBUTENOT LANE operated on a woman, æt. about 30, who had suffered for a considerable period from constant pain in the right loin, which was greatly aggravated at times when her abdomen became distended; the belly was tender, so that she could not bear the pressure of her garments. The swelling and pain diminished slowly, and this subsidence was associated with the passage of a quantity of milky urine. She consulted a medical man who found a tumour in the right loin which he took to be renal. The urine was loaded with pus; it had been examined for tubercle, with a negative result. A radiograph was also taken, but it showed no evidence of stone. When she was admitted into the hospital the condition was practically the same. The right kidney was very much enlarged, its surface was lobulated and firm; pressure on it produced great pain. The ureter was not enlarged or thickened beyond the normal. A further examination with the X rays showed nothing definite. The fact that the ureter was normal as far as could be detected suggested some cause other than tubercle. The kidney and ureter were freely exposed by a long oblique lumbar incision. The latter was perfectly normal to within one inch of its upper limit, where

it entered an inflammatory mass, which was inseparable from the kidney. With much difficulty it was partly cleared, when a small hard, nodular lump was felt. It was very cicatricial, dense, and the lumen of the ureter was clearly constricted irreparably; besides this the kidney substance had been subjected to much prolonged pressure; it was therefore felt to be hopeless to do anything but remove the damaged organ. This was carried out. When the indurated mass was examined it was found to consist of a small stone no bigger than a pea lying in an ulcerated thick walled cavity formed by the upper limit of the ureter. This was surrounded by the dense cicatricial inflammatory material already referred to. The conditions present were such that at this stage of the disease it was evident there was no possible treatment other than that of nephrectomy. This case illustrated very well, Mr. Lane said, the fact that the negative evidence of stone in the radiographic picture, however perfect, does not necessarily eliminate the presence of a small stone, indeed, frequently of one of a fair size. It also illustrated the fact that a very small stone may stick in the ureter, and that it may produce very much more damage to the kidney than one much larger in size in the pelvis. Mr. Lane also urged the importance of examining the ureter thoroughly in every case of obstruction to the flow of urine from the kidney.

### NORTH-WEST LONDON HOSPITAL.

**REMOVAL OF SUPPURATING CHOLESTEATOMA.**—Mr. TEMPLETON operated on a boy, æt. 16, who had been sent up to him by Dr. George Cathcart. The patient was suffering from headache accompanied by pain behind the left ear, with a history of discharge from the meatus on and off for two years. About ten days before admission a swelling commenced to appear behind the ear, which slowly increased, the skin becoming red and oedematous and the headache gradually getting worse; the temperature was 102, and the boy was in a dull sleepy state. There was no facial paralysis and no enlarged glands at the angle of the jaw. The discharge from the ear was slight and not offensive. The ear itself was stuck out, and, owing to the displacement of the pinna, had the characteristic appearance seen in cases of acute mastoid disease. On inspecting the membrana tympani the edges of the small perforation seen were quite healthy. Mr. Templeton said it was rather a curious point that there was so little discharge, and that even this small amount was not offensive, this being, he thought, rather a contra-indication to mastoid diseases. An operation was deemed advisable, and was performed at once after admission. After the part of the scalp adjacent to the ear had been shaved, a curved incision was made a quarter of an inch behind, and parallel to, the pinna; almost immediately under the skin a quantity of pus (three or four drachms) welled up; the mastoid process was then fully exposed, and the portion of bone superjacent to the antrum carefully cleared. Part of this formed the floor of the abscess cavity before opened. The periosteum and other materials were next cleared away with an elevator, and then a small yellowish bulging was noticed in the position of McEwen's triangle. The opening was therefore cautiously enlarged by a gouge, and a small quantity of this yellowish stuff taken up with a spoon. It was found to consist of the putty-like material characteristic of a cholesteatoma. The opening was now still further enlarged, and the

tumour, the size of a large filbert, was lifted up with its capsule and easily removed, the capsule separating from the adjacent bone without difficulty, there being no adhesions of any moment. There was, of course, considerable absorption of bony tissue from pressure of the mass, so that the upper portion of the tumour was in contact with the dura mater, therefore great care had to be exercised in cleaning out the cavity; this was done by first mopping it out, and then thoroughly irrigating it with 1-40 carbolic lotion. The tympanum was not interfered with by scraping through the external meatus, as there had been so little evidence of disease in the middle ear. The cavity was packed with iodoform gauze; a few stitches were placed in the upper part of the wound, the lower part being left open so that subsequent dressing could be applied. Mr. Templeton thought the interest in the case lay in the fact that it closely simulated an ordinary one of acute suppurative of the mastoid; the absence, however, of any offensive discharge, he pointed out, was somewhat in favour of cholesteatoma; the pain, too, had not been very acute. This kind of tumour, he said, was very uncommon. The growth itself, he remarked, was very easy to shell out, in fact, it came away quite in the same manner as an ordinary sebaceous tumour.

The patient was discharged in about a fortnight, and sent to a convalescent home. Only a small sinus remained, and all symptoms were quite relieved.

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### The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, SEPTEMBER 4, 1901.

#### TOWN CHILDREN AND HOLIDAY FUND INFECTION.

THE risk of catching infectious disease is never altogether absent from children who are taken for their summer holiday to a health resort. To a great extent parents and guardians are at the mercy of the lodging-house keepers and the sanitary authorities of the district they have elected to visit. On the other hand, of course, it happens not infrequently that reckless and selfish persons convey the germs of active infection hither and thither in the

persons of sick or convalescent children. But apart from these dangers, which are by the nature of the case restricted to the well-to-do classes, there has of late sprung up a separate and peculiar danger that demands careful consideration in the interests of the community at large. As happens in not a few analogous instances, the evil is wrought by want of head rather than by want of heart, a fact that will be at once apparent to readers when they learn that it is due to the philanthropic effort to send the slum children of our towns for a short holiday in the country during the summer months. A moment's consideration will show that in the absence of efficient medical supervision at each stage of the sojourn the door will be thrown open for the mutual conveyance of infectious diseases of all kind between town and country. The risk is clearly just as great for the country folk as for the citizens. The children sent out are obviously at an age and of a class predisposed to infection, and under ordinary arrangements they are distributed among cottagers whose chief claim to selection is the fact that they themselves possess a family of companionable age with that of their guests. Under such circumstances the town children's holiday movement, unless under rigid medical control, becomes practically an ingenious plan for maintaining the incidence of communicable maladies upon town and country. The principle of this philanthropic movement is above reproach, and it would be a thousand pities were the town children to lose their holiday for want of a little organisation. The question is purely medical and it seems one that should be to a great extent settled by the medical officers of the districts involved. A medical certificate of freedom from communicable disease of any kind, including not only the more commonly recognised specific contagious diseases, but also those of skin, eye, and scalp, should be exacted in the case of each child. A similar certificate should be required of the families visited. Arrangements should also be made for the systematic medical supervision and care of the town children during their absence. In a recent case one of these unfortunate holiday charges was sent back to town in a dying condition suffering from acute abdominal complaint, for which he had received no medical attention in the country. It need hardly be pointed out that all medical certificates and supervision should be paid for and be made a part of the cost of the funds. There is no reason, so far as can be seen, why a special tax should be laid upon the services of members of the medical profession any more than upon the railway companies or the caterers who are employed by the managers of the holiday funds. There is another aspect of this particular branch of philanthropic work with which as a medical journal we are not closely concerned, but which is almost precisely analogous with the intercommunication of bodily infection, namely, the moral damage likely to ensue from planting a number of children bred in

the slums among those who have been reared in the purer and simpler atmosphere of the country. That is a matter, however, for the consideration of those who devote themselves to the ethics of practical life, and we may look to them with confidence to treat the subject with the caution and sense of responsibility that it demands. From a medical point of view, we have felt it our solemn duty to dwell upon the dangers that are inherent to an essentially benevolent scheme. There was never any period in the history of preventive medicine when the necessity of joint action between urban and rural sanitary authorities in the prevention of infectious disease was more fully recognised. In our opinion, it would not be impossible to safeguard the organisation of the Holiday Funds in a satisfactory manner, chiefly by way of stringent medical supervision, and perhaps, secondarily, by an extension of the camp as against the boarding out system. In any case, it is to be hoped that by next summer some well-considered plan will have been framed to meet the exigencies of the present situation.

#### COXALGIA.

To the patient and intelligent study of M. Ollier, of Lyons, we are principally indebted for our knowledge of the pathology of coxalgia. We well remember the earlier pathology that saw nothing but an inflammation, and combatted the disease by killing the inflammation by exciting a greater one. The surgeon gave his whole attention to drawing out the inflammation, and blisters, setons, caustics—actual and potential—were used as the poor sufferer lay a willing victim to the well-intentioned but torturing attempts to kill the disease. Lucky was the victim who lived to afterwards go about on crutches, with the injured limb a useless appendage. Later the joint was cut down on, the bag of pus the capsule held was opened, and the head of the femur excised. It was as a treatment a distinct advance on the older method, and was the first-fruits of the new pathology. Months of suffering were saved to the patient, and the limb was neither so useless nor deformed as by the other treatment. Immobilisation of the joint and good feeding, with outdoor exercise, may fairly be claimed as a natural outcome of the recognition of the tuberculous character of the disease. And when commenced in the earlier stages the results obtained were excellent. Unfortunately patients did not come under treatment in the first stages of the disease when the apparatus and the constitutional treatment offered a chance of an arrest of the disease and the full use of the joint. Yet even in advanced cases progress was marked—a limb of the normal length without deformity, and, though stiff, more comely and useful than a crutch. The great drawback to this immobilisation treatment was the apparatus; as a rule they were costly and cumbersome; badly borne by children and young adults, and if not re-adjusted at short intervals more injurious than bene-

ficial. Where, to secure immobilisation, the child is placed on a bed and the limb extended by weights attached to it, the child suffers from the loss of outdoor exercise, and is liable, lying immovable, to all forms of chest troubles. If brought out on a reclining couch the risks of pulmonary disease are increased. The desideratum of the surgeon—fixation of the joint with mobility of the limb from the hip down—was not secured. To meet the want, M. Paul Archambaud has, especially in the case of infants, recommended an apparatus (*La Revue Médicale*) by which he hopes to secure correction of deformity, immobilisation of the joint during exercise, restoration of the muscular vigour and functional activity of the articulation, and facilities for general treatment. His lines of measurement are from the anterior spine of the ilium to the superior external border of the patella of the same side, and from the anterior superior spine of the ilium to the tuberosity of the ischium; and from the ischium to the patella as above. By drawing a base line from the anterior superior spine of the ilium to the tuberosity of the ischium a base line of an acute triangle is formed, whose apex reaches to the superior border of the patella. Made with adhesive plastic material this immobilises the joint and yet allows of exercise. To secure good results both sides are bound by the apparatus. We hope the results may equal the author's expectations; but we confess to a certain amount of scepticism of new apparatus for the hip joint. Since our early student days we are familiar with new apparatus for fractured clavicle new splints for Colles' fracture, and new methods of immobilisation of the hip-joint. An apparatus to secure the advantages for the patient that M. Paul Archambaud claims his will give is much to be desired, and we wish the distinguished surgeon every success in his attempt to improve our treatment of coxalgia.

#### TREATMENT OF ACCIDENTS UNDER CHLOROFORM.

THE treatment of accidents under chloroform is a question full of interest to most medical men, and one, too, on which all who undertake to administer the drug should have formed some definite opinion. In the recent numbers of the *Manchester Medical Chronicle* Mr. Wilson, Administrator of Anæsthetics, Royal Infirmary, Manchester, endeavours to classify the different accidents which are likely to occur, and to consider the mode of action and range of utility of the various remedies which have been suggested. The three classes which he adopts are shortly:—

1. Irregular and uncontrolled action of muscles during the stage of excitement.
2. Paralysis or loss of tone of muscles altering the patency of the respiratory passages and so causing mechanical obstruction to the breathing.
3. Specific paralysing action of the drug on the fundamental nerve centres in the medulla.

It is obvious that few cases of danger can be allocated to any one of these classes, for even presuming that the danger arises at

first from the irregular action of certain muscles interfering with respiration, still what makes this really serious is the danger of the sudden onset of the specific paralyzing action of the drug on the medullary centres. It is probable that any classification of accidents would be open to similar objections, but if it enables the administrator to grasp more clearly the general principles of danger it must be considered to have answered a useful purpose. The indications for treating these accidents are three-fold — to remove the anæsthetic-laden air from the lungs, to encourage the flow of blood to the nerve centres, and to stimulate the circulation and respiration. The various methods which are used to attain these ends Mr. Wilson groups into five classes—1. External reflex respiratory stimulants; 2. Direct mechanical or electrical stimulation of the heart; 3. The mechanical performance of natural functions such as artificial respiration; 4. Mechanical measures designed to counteract the effects of the failure of the circulation by raising the general blood pressure; 5. Drugs administered to stimulate the depressed nerve centres. Of the first group, the best that can be said is that they do no harm unless persevered in to the detriment of more important measures, and of the second, that they are either impracticable or positively harmful. Faradic stimulation of the precordial area, if any of the current reaches the heart, probably inhibits its action. Acupuncture of the heart is equally useless, and direct manipulation of the heart after opening the heart-chest is a remedy which requires more evidence of its utility before it can be recommended. Mr. Wilson believes that as good, if not better, results, can be obtained by intermittent pressure on the chest wall, accompanied by alternately raising and lowering the patient so as to empty and fill the heart. The difficult question has first to be decided whether the circulatory failure is the result of paralytic dilatation of the heart, or of paralysis of the vaso-motor mechanism. The methods of treatment suitable for each of these cases are absolutely antagonistic, and it is by no means easy to say which is the cause in any given case. It would appear that sudden failure of the circulation, accompanied by pallor of the face, and accelerated or gasping respirations denotes vaso-motor paralysis and requires inversion of the patient with pressure on the abdomen. On the other hand, if the dangerous symptoms are preceded by struggling, and the face is suffused, with signs of venous engorgement, the patient should be alternately raised to nearly the vertical position in order to empty the heart, and then returned to the horizontal position. Artificial respiration should be systematically persevered in in each case. If there is actual failure of the circulation little that is useful can be done by efforts to raise the blood pressure by such means as transfusion, &c. The same objection also applies to the use of drugs. Where there is failure of the respiration or circulation the difficulty is to get the drug to the nerve centre which it is to

stimulate. In those cases in which this can be effected hypodermic injections of strychnia and the extract of suprarenal capsule, with inhalation of ether, are probably the most useful.

## Notes on Current Topics.

### The Duration of Pregnancy.

It would seem that in the human organism those phenomena which are of the most everyday occurrence are usually the most difficult to explain. A concrete example of this is given by the various phenomena of pregnancy. Pregnancy is, one would think, a sufficiently long-established condition to enable us to understand something about it, and yet our ideas on many points connected with it are of the vaguest description, and our definite knowledge practically non-existent. When does impregnation occur? Where does impregnation occur? What are the causes of the onset of labour? What is the exact duration of pregnancy? and, Is there a fixed period for gestation? Perhaps the most practically important of these questions, not alone to medical men but also to the legal world, are, "What is the duration of pregnancy?" and, "Is the period of gestation capable of variation?" Of course the time which is usually fixed in the medical and lay mind is a period of ten lunar months, or nine calendar months, or 280 days. The statistics of Loewenhardt, Hasler, and Hecker, obtained from the records of a large number of cases in which pregnancy resulted from a single coitus, gave an average duration of from 272.2 to 273.5 days, a period which is somewhat shorter than the popularly accepted one. Perhaps the latest statistics on this interesting subject are to be found in a recently published article by F. von Winckel. The writer considers that as the methods of estimating the length of human pregnancy hitherto proposed have proved unsatisfactory, the important question whether a pregnancy had been unduly prolonged might be better determined by estimating the length of the gestation of abnormally large and heavy children at birth, and comparing this with the average duration of pregnancy in all uninterrupted cases. During the thirty years he had charge of the clinic at Dresden and Munich he met with 1,007 children over 4,000 grms. when born. Only five were over 5,000 grms., and the heaviest was 5,320 grms. v. Winckel draws a series of conclusions of which the following are the most important:—Prolongations of pregnancy, that is to say, delayed labours, undoubtedly occur; important evidence of their occurrence and of their frequency is given by the number of children which at birth weigh 4,000 grms. or upwards; the frequency of such children in large clinics amount to 3.15 per cent., and about 14.5 per cent. of them have been more than 302 days in the uterus. The frequency of delayed labour is 2.8 per cent. The proofs now advanced that so many children (14.5 per cent.) remain more than 302 days in the womb shows that this, the German limit of legitimacy, is too low.

### Ovarian Extract.

THE trend of modern therapeutics has of late been in the direction of organo-therapy. In most cases glands with external secretions contain a member of the group of ferments, but in the case of the internal secretions of glands the product is usually of a complex substance, and it is exceptional for it to be of the nature of a ferment. Thyroid extract, orchitic extract, and supra-renal extract, together with ovarian extract, are among the latest additions to the list of therapeutic agents. The reason underlying the administration of these extracts is the undoubted fact that diseases may be caused by interference with the activities of these glands. In the case of ovarian extract an extremely interesting report has just been issued by Dr. Krusen in the Johns Hopkins Hospital *Bulletin*, in which he gives his experience for the past three years of the use of this extract in amenorrhœa, in dysmenorrhœa, in those suffering from symptoms following the removal of the uterine appendages and for the disturbances in connection with the menopause. The conclusion arrived at is that the theory of the use of this extract is faulty, and its administration based upon a wrong assumption as to the function of the organ. This is quite in agreement with the views of many authorities on therapeutics, but it is certainly reassuring to be told that the extract is practically harmless. In those cases where relief has been noted it is questionable whether the improvement was not due to mental suggestion, and it is quite evident that no definite reliance can be placed upon the preparation.

### A Penny a Week for the Doctor.

EVERY now and then the medical world receives a sharp reminder that Nemesis sits behind their want of business method. Sooner or later the reduction of fees that has resulted from unworthy competition educates the public into the belief that all medical advice should be obtainable at a low remuneration. The tendency then naturally arises to cut down salaried appointments, an occurrence that is reported almost every day of the week in various parts of the United Kingdom. An instance of this grinding economy was shown last week by the Mile End Board of Guardians. That body has taken the progressive step of boarding their Poor-law school children out in scattered homes. When the question of medical attendance came under discussion it was reported that some medical men had agreed to attend when necessary, and to supply medicines and dressings at sums varying from sixpence to threepence per week per child, while one doctor tendered at twopence. Even the last-mentioned offer failed to secure the acceptance of the guardians, who have deferred the matter to a sub-committee, on the ground that the "figures were too high." One of them said that he paid only a penny a week for his doctor, a statement which appeared not to have caused him any shame or compunction. Clearly, medical men have themselves to thank for the

diminished estimate of their public worth by attaching so low a value to their services to clubs and medical aid societies, to say nothing of other kinds of cheap and gratuitous work.

### Fatal Treatment of Aneurism by the Gelatine Method.

TWO cases of considerable medical interest were investigated last week at Guy's Hospital by the City of London coroner. As most of our readers probably know, a new method of treating aneurism by the subcutaneous injection of gelatine has recently been introduced. One of the house-surgeons at Guy's, Mr. L. Stamm, had three cases of thoracic aneurism under this specific treatment. He himself sterilised the gelatine, of which several ounces were injected into the leg or other part of the body, so as to enter the general circulation, where it increases the coagulability of the blood and so leads to the consolidation of the sac. Of the three cases thus treated one was discharged cured, while the two others developed tetanus and died. There can be no doubt that the specific organism of tetanus was introduced along with the gelatine. This accident is most unfortunate, as it will tend to cast a stigma upon what is undoubtedly a valuable scientific method of treating an incurable disease. No blame can be attached to the house surgeon, who had taken every precaution possible from a human point of view. The treatment was first introduced by Lancereaux, of Paris, who administered every six or eight days four to five grammes of gelatine in two hundred cubic centimetres of 0.7 chloride of sodium solution. If properly sterilised there should be local reaction at the point of injection. Lancereaux reported five cases of aneurism, of which three were cured. It is therefore obviously unfair for the newspapers to speak of the method as hospital experimentation upon patients.

### Anti-Vivisectionists, Take Note!

THE worthy folk who refuse to sanction experimental inquiry into physiology and disease in the lower animals must find plentiful matter for wringing of hands in the busy universe of science. Pathological laboratories are being daily added to all our large general hospitals, where technical vivisection is carried out on a large scale in order to discover what is the exact nature of the maladies from which patients are suffering in the wards. To take an example: a patient is afflicted with some obscure lung complaint, as to which prolonged and careful observation has failed to form a decided diagnosis. A portion of his sputum is inoculated into the tails of a couple of white mice, or under the skin of two or three guinea pigs, and it is noted whether the animals recover or die, and if the latter, whether they succumb to pneumonia, tubercle, or some other disease set up by known micro-organisms. The verdict thus obtained, due technically to vivisection, is clearly of vital importance to everyone concerned. On the one

hand it may carry the death warrant of the patient, or, on the other, may determine a course of treatment which will end in his complete recovery. Without a biological test of the kind in doubtful cases no physician could sincerely say he had given his patient the fullest advantages afforded by modern scientific medicine. The matter, therefore, resolves itself into a direct balancing of the lives of mice and guinea-pigs against those of our fellow-creatures. Which is to win? Medical men are on the side of humanity, on which side are the vivisectionists?

#### British Medical Association Meeting, 1902.

THE announcement has been made that the next annual meeting of the British Medical Association will take place at Manchester. As a busy Lancashire centre that town offers a considerable contrast from Ipswich and Cheltenham, the last two places visited. The population of Manchester is over 500,000, while its suburb, Salford, contains 198,000 persons. A large increase has taken place in this direction since the last visit of the Association some twenty-five years ago. The proportionate growth, however, has probably nothing like equalled that of the Association, which now reckons some 19,000 members. The President-elect is the well-known surgeon, Mr. Walter Whitehead, who has held many surgical appointments in the city, as well as the professorship in clinical surgery at Victoria University. The association of the place with a young and vigorous University will doubtless add to the brilliancy of the meeting from a scientific point of view. It will be of much interest to note the course of affairs now that the constitution of the Association has been so materially altered.

#### Medical Miracles.

THE fashion of the present day is to consider that medical miracles in the healing of the sick occur only with Christian Scientists or at Lourdes. The following two cases, out of others, are sufficient to show to all unbiassed minds that what may be justly described as miraculous cures occur now and then in patients under the care of duly qualified practitioners of medicine. The first case is given on the unimpeachable evidence of Dr. Osler, of Baltimore. A woman came to him with cancer of the breast, and on his advice it was thoroughly removed by Mr. Halstead. The prognosis was, of course, unfavourable, and two years afterwards she came again to Dr. Osler, suffering from sarcoma of the choroid. The patient went from bad to worse, and in June, before going away for his holiday, Dr. Osler went and said good-bye to her. She was then in great pain, secondary tumours had appeared near the breast, the liver was invaded, and she was paraplegic. A year later Dr. Osler was astonished to find that the nodules round the breast had gone, she had recovered from the paraplegia, and she was regaining vision in the affected eye. A short time ago this lady went two miles to the railway station to meet Dr. Osler. A yet more astounding recovery has been reported.

About four years ago Mr. Tiffany, a surgeon, removed at Dr. Osler's request a cancerous breast, and the case appears to have at first followed the usual course—that is to say, secondary growths made their appearance. About twelve months ago she was not expected to live, and she complained much of girdle pain, and pains down the leg, ultimately becoming paraplegic. The woman, however, did not die, but gradually improved and went away into the country. A few months ago this patient walked a considerable distance to see Dr. Osler, who found that she still had some secondary nodules and a certain stiffness of the back. She continues to take morphine, but gets about and attends evening parties and general entertainments of that kind. There is no desire on the part of the medical profession to put themselves into competition with the therapeutical agencies mentioned above, but it is well to remember that there is no monopoly even in so-called miracles.

#### Christian Science "Testimony" Meetings

THE *British Monthly* for September reports some astounding "testimonies of cures" said to be adduced at the meetings of this strange cult. "Were there no fools there would be no knaves" is a dictum more frequently exemplified in quackery than in aught else with which we are acquainted. Unfortunately there are always considerable numbers of emotional people with little to do, who are ready at any moment to be carried away by the latest craze. In this case we have educated and aristocratic people making themselves ridiculous in the eyes of their neighbours. They are a psychical study, and therefore the advice given in the *British Monthly* is worthy of careful consideration. It says: "If doctors of repute would attend the Wednesday evening testimony meetings, and talk privately with the men and women who describe these cures with such evident sincerity, they would be able to judge for themselves of the facts which at the present moment are so puzzling to inquirers. So long as the narratives remain unsifted, credulous and excitable people will, we fear, be more and more drawn into the ranks of the Christian Scientists." Quite recently an American physician offered a cheque for £200 to anyone who would bring forward convincing evidence of a complete cure being effected of any bodily deformity by the methods referred to. The issue may be awaited with confidence, for there is not the slightest risk of the depletion of the bank balance of the medical man in question by his apparently sporting offer. We would here draw the attention of the editor of the *British Weekly* and the *British Monthly* to the objectionable advertisements in journals supposed to circulate among clergymen. He there serves up as a literary hash from his own pen "The Religious Use of Memory," with advertisements inviting readers to a free trial of galvanic belts, free trials of cures to all the ills to which human flesh is heir; the "cure of consumption" by E. W. Alabone, &c., which make most unsavoury and questionable reading. Such advertisements do much harm, and yet they



continue from week to week and month to month. As the editor professes his anxiety to know the truth of the so-called "cures" by Christian Scientists he should give evidence of his zeal by taking care that his readers shall not be driven hither and thither by so many forms of rampant quackery. One at a time should be enough for their mental balance.

### Obesity and Politics.

ACCORDING to some lately published statistics the number of fat men counted in a first-class hotel, out of a total of 100 was seventy. The statistician is not so rude as to call these gentlemen fat or even to style them obese, he politely refers to them as men from the age of twenty upwards who showed an abnormal development in the abdominal region. It would further appear that these well-covered gentlemen included in the 70 per cent. united imperialistic politics with their inclination to *embonpoint*. The medical journal giving these figures infers, somewhat severely, that imperialism is usually obese in type. In a hotel frequented by the upholders of democratic principles the percentage of fat men was only eleven, and the conclusion drawn is that if democracy and radical ideas are to be maintained, careful heed must be taken to prevent any undue tendency to abdominal expansion. The energetic compiler of these statistics pursued his observations in a residential quarter where the dwellers were well known to hold imperialistic views and the percentage of fat men was 35; in a radical suburb, however, the percentage rates of obese personages was 14. It has not been attempted before to maintain a connection between obesity and imperialism by means of statistics, which are notoriously fallacious, but both among adults and children there is certainly an increase in the number of persons corpulent to the degree of deformity. It is generally supposed that luxurious and sedentary methods of life with over-indulgence in sleep and absence of mental occupation are among the recognised predisposing causes of obesity, and though it may be convenient to suggest the cult of imperialism as the cause, the true bearing of the figures cannot be overlooked that increased prosperity generally means increased self-indulgence with its attendant drawbacks.

### Surgical Interference in Appendicitis.

THE question of the surgical interference in cases of appendicitis is one which as yet can hardly be said to be satisfactorily settled either from the point of view of the physician or the surgeon. In the August number of the *Edinburgh Medical Journal* Mr. Walter Spencer helps materially towards its solution. Mr. Spencer classifies these cases clinically as follows: (1) Cæcal distension. In these cases the treatment is purely medical and the prognosis good. (2) Perityphlitis. This may yield to medical treatment, but if it produces adhesions they may necessitate surgical interference later. (3) Appendicitis proper, of which there are four varieties.

(a) Acute perforation in which early operation affords the only chance of success. (b) Suppurative appendicitis in which extra-peritoneal draining of the abscess should be done as early as the diagnosis can be made. (c) Relapsing and recurring appendicitis, which must be distinguished by careful examination after the attack, and if the signs of chronic appendicitis are found the appendix must be removed at once. (d) Chronic latent appendicitis with septic anæmia is the most difficult of all varieties to diagnose, and there is great danger that it will not be recognised till too late for useful surgical interference.

### Motoring versus Horse Exercise.

THE great Horse Show in Dublin last week at which there was so brilliant a gathering both of feminine and equine beauty, recalls the medical mind to a contemplation of the physical effects likely to compass future generations by the use or misuse of the vehicle which is to supersede the horse for locomotion and exercise. We believe that the old hygienic proverb "the outside of a horse is the best medicine for the inside of man," has been received within the canon. We may perhaps be permitted to add of our own personal inspiration that a thoroughbred woman seated on a thoroughbred horse represents the highest standard of human grace and dignity in physical exercise. With the growth and multiplication of the motor car one of the most telling factors in the production and maintenance of a perfect physique must necessarily dwindle more or less rapidly. Horse exercise will gradually become less immediately useful and less fashionable. The bicycle rider could say much in favour of his mode of progression, even although neither graceful nor dignified. Now we have the "motor," favoured by "business-men" because of its swiftness, and by snobs and *parvenus* because of its expensiveness. Its vibrations may recall to the memory of our readers the *chair* so ostentatiously used by the well-known French specialist in the treatment of some forms of nerve disorder, and the element of explosiveness may bring up recollections of the "earthquake treatment" of hysteria. That its discordant notes must modify the auditory and collateral centres is, we think, unquestionable. Accordingly, we fully anticipate the development of new features—some of them of a decidedly pathological tint in the future generations of the votaries of the motor car. Of course further progressive modifications may tone down or remove some of those features of its construction and action which we now feel least disposed to admire. That there are too many horses on the streets of our large cities must have been strongly felt by any person who lived in London during the burning days of the past July. So that the multiplication of motor cars will at least tend to lessen one of our substantial metropolitan grievances. Its early defects may be rapidly outgrown, like those of other infancies, under judicious culture, so that there may be hope for the

future of the "motor," although we confess, for the present, to a feeling of discomfort in that quarter.

#### The Certification of Lunatics.

OUR readers will recollect a resolution passed by the Belfast Board of Guardians on June 5th with regard to a change in the procedure at present adopted in certifying lunatics, in which, among other points, it was suggested that the Poor-law medical officer should be obliged to visit the supposed lunatic at his residence, and, from the results of that visit, issue a certificate of lunacy if necessary. For this task, the medical officer was to receive the magnificent fee of five shillings. We suggested at the time that such a procedure was illegal, and that it was doubtful if so radical a change could be made, and we are glad to find that the Local Government Board take the same view. It is unnecessary to dwell on the absurdity of the fee, or on the almost insuperable difficulties which would surround the medical officer in the discharge of such a duty. The following is the reply of the Local Government Board:—"The Local Government Board have had before them the resolution adopted by the Board of Guardians of Belfast Union on the 4th ult., respecting the procedure to be adopted in the removal of lunatics to the District Lunatic Asylum, and the Board desire to state that they are advised that the proposed arrangement could not be carried out under the existing law, because there is no legal duty as to the examination and certifying of lunatics other than dangerous lunatics imposed upon dispensary medical officers, and no legal authority to pay the fee or other expenses incurred out of the poor-rate. In these circumstances the Board regret that in the present state of the law they are unable to approve of the arrangement proposed by the guardians."

#### Post-mortem Risks.

THE increasing number of post-mortems that are now made both in this country and abroad is not unattended with certain serious risks, some of them capable of being easily prevented, others unfortunately, however, offering greater difficulties. A striking example of the latter type of danger is well shown in the account published by a Dr. Fuenrohr of his own attack of typhoid fever from infection to which he was exposed at a post-mortem on a case of enteric. The autopsy unquestionably was conducted with the most scrupulous attention to every precautionary detail, but the facts nevertheless point undoubtedly to the truth of the assumption that the fever was imparted to Dr. Fuenrohr at the examination of the body. The only explanation of the way in which the infection was carried is that during the process of rinsing the intestine with water, which he, as usual, effected by means of running water, small particles of virulent matter were splashed upon him. The possibility of this accident occurring is not sufficiently appreciated by those whose duty it is to conduct autopsies, and means should be devised to pre-

vent typhoid infection from this method of washing the bowel for the purposes of investigation.

#### Disreputable Advertising in "Reputable" Journals.

MANY of our home journals might with advantage copy the action which has been taken by the Philadelphia *Times*, under its new management, and which can be gathered from the following resolutions recently passed by the Medico-Legal Society of that city:—"Whereas, the advertising of abortionists and their drugs, as well as other disreputable secret medicines, has for years been a notorious disgrace to the newspaperdom of this city, an evil seemingly without redress, and, Whereas, the Philadelphia *Times* under its new ownership has declared for a high ethical plane, avoiding all sensationalism, while at the same time furnishing 'all the news that is fit to print,' excluding all medical and other questionable advertisements so as to make it indeed a newspaper fit for the family circle, therefore be it Resolved that the Medico-Legal Society of Philadelphia highly approves of the advanced stand taken by the *Times* and urges upon the medical profession generally its active support in aiding to carry out that journal's elevated ideals." There are papers in Great Britain also laying claim to the title "family" which are a disgrace to journalism and an insult to moral standards by reason of the advertisements they admit into their columns. We fear it is too much to hope that they will take a lesson from the foregoing until compelled by law to do so.

#### Pregnancy Following Myomectomy.

SOME years ago Dr. Alexander, of Liverpool, read a paper before the British Gynæcological Association on the removal of multiple myomata of the uterus by myomectomy through a single incision in the uterine wall. The operation was not received with any great favour at the time, as it was thought that the uterus after this proceeding would be so mutilated as to render its absence preferable to its presence. Accordingly, it is interesting to find that in the *Medical Record* for August 17th Dr. James N. West, in a paper records a case in which he removed sixteen tumours, through nine incisions, from the uterus of a woman on March 16th, 1899. On January 8th, 1901, he attended the same patient in her confinement, when she was delivered after a perfectly normal labour, lasting twelve hours, of a healthy boy weighing 7½ lbs. In spite of the extensive scars in the uterus the expulsive force was ample, and the only complication was a lacerated perinæum. Dr. West gives an interesting analysis of the recorded cases of pregnancy following myomectomy.

THE Society of Apothecaries, London, announce that the Gillson Scholarship in Pathology, value £90, will be open for competition in January next. Competitors must hold the L.S.A., or obtain it within six months after gaining the scholarship. Further particulars can be obtained of the Secretary to the Examiners.

**The Doctor in Fiction.**

It is apparently almost impossible for the writer of fiction to touch upon medical subjects without falling into error, and an exceptionally glaring instance is afforded in Mr. Hall Caine's novel, "The Eternal City," that has just been published. Chapter VIII. of the part of this work entitled "The Roman of Rome" describes how a medical man examines the breast of a patient and the glands under her arms, and, finding cancer, announces that a nurse must be summoned immediately. On the next page this practitioner, who is supposed to be the most costly and fashionable doctor in Rome, is made to tell the friends that if the cancer had been diagnosed earlier *nephrectomy* might have been possible, but that the case as he found it was beyond the reach of legitimate surgery. Mr. Hall Caine has portrayed in an earlier novel an impossible hospital nurse, but the medical man he has presented us with in "The Eternal City" is more impossible still.

**Are Rontgen Rays Infallible?**

A NUMBER of papers have been recently written concerning the fallacies and difficulties in the diagnosis of fractures by means of the Röntgen rays. A case has recently come under our notice which illustrates forcibly the difficulty in localising foreign bodies in the alimentary canal below the œsophagus. A patient swallowed a dental plate made of gold with two teeth attached. When admitted to hospital the plate had passed the cardiac orifice of the stomach. For three consecutive days an expert radiographer manipulating the most up-to-date apparatus failed with either fluoroscope or sensitive plate to demonstrate the presence of the denture, and this notwithstanding the fact that buttons, coins, and other objects could be distinctly seen through the whole thickness of the body. The peristaltic movements of the intestines would account for the failure in the case of the photographic plate, but it is difficult to understand how these movements would interfere with the view obtained by means of the screen.

**Inoculation in Enteric Fever.**

THOSE interested in the preventive treatment of enteric fever by inoculation are still looking forward to the results of the statistics on this subject which may be derived from the Army Surgeons in South Africa. The figures given by Mr. Andrew Balfour, late Civil Medical Officer, South African Field Force, in his paper entitled "A Ship of the Veldt," in the current number of the *Edinburgh Medical Journal*, are of great interest. The figures cover a period of five months, and are as follows:—

	Admitted.	Recovered.	Died.
Inoculated	92	89	3
Uninoculated	551	511	40
Died inoculation unknown			17
Percentage mortality of those inoculated,	3.25.		
" " of those not inoculated,	7.2.		

In all cases the diagnosis was confirmed by Vidal's reaction. and though the number of the cases is not sufficient to base any definite conclusions, still the results must be regarded as eminently satisfactory.

WE regret to learn that Dr. Alfred E. A. Lawrence, Professor of Midwifery and Diseases of Women in University College, Bristol, died suddenly on the 30th ult. while on holiday with his family at Bishop Steignton, Devon. He was supposed to be in good health when he left Clifton three weeks ago, and the news of his sudden death has been received with startling surprise and sincere regret in Clifton.

AT the meeting of the British Association for the Advancement of Science, to be opened at Glasgow on September 11th, Major Ronald Ross, I.M.S., will read a paper on "Tropical Parasitology."

MR. TREVOR N. SMITH, J.P., F.R.C.S.I., has been appointed Assistant Master of the Coombe Hospital, Dublin.

**Correspondence.**

[We do not hold ourselves responsible for the opinions of our correspondents.]

**VERATRUM VIRIDE IN PUEPERAL ECLAMPSIA.**

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Your annotation on the value of *veratrum viride* shows the continued faith of American physicians in one of the oldest remedies for puerperal eclampsia. It was the remedy of the "medicine man" from Manitoba to the Gulf of Mexico, and its use by the Indians introduced it to the first settlers in the Colonies. As far back as 1849 Dr. Porcher published an account of its therapeutic properties, and soon afterwards Dr. Norwood, of South Carolina, published in the *Charleston Medical Journal* his formula for the tincture, which there is known by his name, and has been freely used throughout the United States. He recommended it to be given in "six to eight drop doses, repeated cautiously." I fear the dosage you mention, "fifteen to sixty minims of Norwood's tincture" every fifteen minutes, could not be taken, for such a dose would act as a powerful emetic and produce toxic symptoms of an alarming character.

Indeed, Norwood's tincture is so strong that it has been latterly displaced by one not half the strength. The *Am. J. Pharmacy*, N.S., iv., p.89, gave a formula for a tincture so weak that the ordinary dose was thirty minims.

The fullest account of the therapeutics of the drug is H. C. Wood's: "A contribution to the knowledge of the physiological action of the alkaloids, *viridia*, *veratroida*, and of the resin of *veratrum viride*," published in 1870, as a reprint from the *Am. J. Med. Sc.* He concludes that "*Veratrum viride* slows the pulse by a direct depressant action on the heart muscle, and by stimulating the pneumogastric nerves; it lowers blood pressure by action on the heart muscle and by depression of the vasomotor centre."

The more recent investigations by Dr. C. Briz are even less favourable to the drug.

Of its action on the heart he writes:—"At first there is a continuous stimulation and increase in the pulse-rate and in the blood-pressure. The duration of the contraction then becomes longer and longer, the rate being diminished to one-half owing to the duration of the systole. All parts of the heart finally become insensitive, even though it still contracts occasionally. atropine now produces no effect. The pulse-rate and

blood-presence gradually become less and less, and if artificial respiration has been maintained, death takes place from paralysis of the heart."

Veratrine, which Meisner discovered in the seeds of *cevadilla* in 1819, and in his description of it in 1821 was the first to use the word "alkaloid," is not found in the rhizome of either *veratrum viride* or *veratrum album*. The product obtained by M. M. Pelletier and Casenton, in 1819, in the root of *veratrum album*, was a mixture of *jervine* discovered by Semon in 1837, and *veratroidine* discovered by Bullock in 1865.

The last named alkaloid slows the pulse by stimulating the pneumogastric centres, and finally quickens it if given in very large doses by paralyzing the peripheral vagi. In toxic doses it causes purging and vomiting.

Jervin according to Hare, causes great slowness of movement, relaxation of the muscles, through which thrills continually run, and finally the animal falls to the ground. Violent epileptiform convulsions may now ensue, but no tetanus is present. The convulsions now give place to paralysis, and are characterised by their lack of force. Sensation is not affected until the near approach of death brings on anæsthesia.

The convulsions are due to the disturbance of the circulation at the base of the brain (Wood), and the spinal cord is directly depressed by the effect of the jervin on its motor tracts.

The tincture of the rhizome of the plant is the preparation generally used. In some parts of the Continent Norwood's tincture is the favourite, and his writings are favourably quoted by Dr. Gaetano Malacudd in his "Manuale de Materia Medica," 1896. The drug is also recommended by Dr. Larea z Cerezo in his "Diccionario de Medicina," 1894. In Germany it is well spoken of in the writings of Kocher, 1866, Liebmeister, 1876, and Pégaitar (*Arch. f. Klin. Med.*), 1869. Reference to its anti-pyrexial properties are frequent in French medical literature. Trousseau's recommendation of the *veratrum album* needs no repeating. I may just add that the chemical composition, *veratrum viride*, is closely analogous to that of *veratrum album*, and the specific distinctness of the American *veratrum viride* from the European *veratrum album* is very doubtful. Certain Alpine forms of the *veratrum album* are said to exactly resemble the *veratrum viride*.

I am, Sir, yours truly,  
F.R.C.S.

## Obituary.

### DR. H. C. BUCKLEY (KENSINGTON).

DR. HENRY CHILD BUCKLEY, whose death from heart failure has taken place, at the age of 57, at his residence, Linden Gardens, Kensington, was the son of Mr. James Buckley, of Penyfai, Llanelly, at one time high sheriff of the county. After going through his curriculum at St. George's Hospital, London, he obtained the L.S.A. and M.R.C.S., and subsequently he took the M.D. of Aberdeen University in 1868, and commenced practice in his native town of Llanelly, and was appointed medical officer of health, which position he held for many years. Possessed of ample means, he retired from practice in 1890 and left Llanelly to reside in London. On several occasions Dr. Buckley was asked to stand as a candidate for the Parliamentary representation of the Eastern Division of the county, and also for the Carmarthen Boroughs, but this honour, however, he firmly declined.

## Literature.

### LAWRIE ON CHLOROFORM. (a)

It seems paradoxical that anæsthetics should excite passion and stir up strife. But from the first it was so. Edgeworth, Southey, Coleridge, Davys, and Beddoes had

(a) "Chloroform; a Manual for Students and Practitioners." By Edward Lawrie, M.B. Edin., M.R.C.N. Eng., Lieutenant-Colonel I.M.S., Residency Surgeon Hyderabad, Principal of the Hyderabad Medical School. London: J. and A. Churchill. 1901.

just tested the properties of nitrous oxide gas, and Count Rumford was securing Davys' services to popularise it and other chemical discoveries, when Mitchell uttered his warning that nitrous oxide was a lethal agent and should be banished from the laboratory and the lecture room.

A whole library of books tell of all the heart-burnings that followed on Crawford W. Long's introduction of ether as a general anæsthetic, even Simpson's introduction of chloroform called forth the Waldie and other controversies.

But worst of all came the heated discussions that followed each attempt to learn the physiological action of the different anæsthetic agents. The interpretation of each fact was disputed with a warmth of feeling and a lack of courtesy quite out of place in considering a scientific question, and such as we associate with religious controversy alone.

Dr. Lawrie's book keeps clear of controversy, though he finds it necessary in the introduction to recount the circumstances that led to his series of cross-circulation experiments, and to print Dr. W. H. Gaskell's letter telling why Dr. Gaskell and Dr. Shore's experiments failed; the ligature which Shore tied at the time of establishing the cross-circulation "was not tight, so that the injection was able to pass both into the vertebral and into the arm on that side."

The book is divided into five parts and an appendix; in the first part the author considers the physiological action of chloroform; in the second he deals with the application of the physiology of chloroform to practice; in the third he considers how to give chloroform; in the fourth he gives his clinical observations; in the fifth he details a few original experiments made in Hyderabad to illustrate the points in the physiological and clinical portions of the work.

The book to the student of medicine—and every member of the profession worthy of the name is a student of medicine—is worthy of attention and careful reading. It is the outcome of years of study by one who possesses the intuition of Claude Bernard as an experimentalist, the dexterity in carrying them out and the capacity of making them intelligible of a Hunter. We have had many books on this subject—books that told of the industry of the compilers, and were creditable as evidences of the author's familiarity with the literature of the subject, narratives of long and fruitless physiological experiments, on frogs, amoeba, dead tissue, and so forth—labours as useless for scientific purposes as those of the philosophers of Laputa. We have read of instances of anæsthesia in many varying compounds that might one and all have been made by any druggist's assistant, and we have books made up of such *olla podrida* occupying our shelves. They reflect no credit on British medicine; they in no way advance science; they contribute nothing to our stock of knowledge.

Standing apart from these, different with the difference born of genius and originality, are the works of Snow and Lawrie. Their works are as a bright light in a dark place, they make clear the path, they point out the safe road that scientific knowledge has traced for the guidance of all who desire to follow. Since Snow's book appeared no such valuable book on anæsthetics has been published as Dr. Lawrie's.

### PAKES' HYGIENE. (a)

THIS book is the most complete laboratory guide to public health work hitherto published. Its author has gained the necessary experience for teaching purposes as bacteriologist and demonstrator of sanitary science at Guy's Hospital. His aim has been to treat the whole of the practical work required for a public health diploma. He has divided his subject into five sections, namely, bacteriology, microscopy, chemistry, physics, and vital statistics. Under bacteriology is given a concise description of the more important bacteria and the method of their examination. The section of microscopy is particularly

(a) "The Science of Hygiene." By Walter C. C. Pakes, D.P.H., F.C.S., Bacteriologist and Demonstrator of Sanitary Science, Guy's Hospital, &c. London: Methuen and Co. 1900. Price 15s.

full and will be found of special value to the student who is preparing for examination. There are numerous illustrations which add materially to the usefulness of a book of this kind, which is presumably intended to be at the worker's side in the laboratory. The plan adopted by the author is systematic and clear. In dealing with the chemical analyses of albuminoid ammonia, for instance, he first describes the process in a series of pithy sentences, to which he appends an "explanation," giving the *rationale* of the proceeding. Short notes are added dealing with points of importance. In most cases examples are given of problems that have been actually worked out in the laboratory, so that the student is able to follow the practical application of his knowledge. In reviewing this book one recognises the great development that public health has experienced during recent years. While it is most essential that earnest scientific workers such as Dr. Pakes should undertake high standard researches, it is evident that they are somewhat outside the field of labour of the average medical officer of health. All who have to encounter high standard examinations, or who wish to have a trustworthy book at hand, either to guide their work in the laboratory or to use as a book of reference, may with confidence be advised to buy forthwith Dr. Pakes' excellent volume.

#### BARR'S DISEASES OF THE EAR. (a)

THE fact that this excellent manual has already passed through two editions, and has now entered on its third, testifies to the worth of the book.

Dr. Barr lays down in the preface that his aim is "to present the main facts of otology in such a form as to meet the wants of medical students and practitioners." This end is quite achieved. Without giving too many details he has contrived to present a picture of otology which should be of great benefit to advanced students and practitioners of medicine.

The first six chapters are devoted to a general survey of the symptomatology, methods of treatment, &c., of ear diseases and those of the nose and throat which may be in relation to them. The remaining chapters describe more in detail the various subdivisions of aural disease. The chapter on the "Treatment of Intracranial and Vascular Complications of Purulent Disease of the Middle Ear" is especially deserving of praise, the illustrations being particularly good.

Special chapters are allotted to "Tinnitus Aurium" and "Deaf-mutism," in the latter of which the author states, with truth, that instruction by lip-reading to adults who have become totally deaf after childhood, and can make out but little of what is said to them is not sufficiently taken advantage of.

The method shown at page 18 as being Politzer's way of inflating the middle ear was not in general use in his Clinic in 1899. As the book is more particularly written for students and general practitioners the addition of a full page diagram of the normal membrana tympani might be of advantage.

A very useful appendix gives a list of formulæ recommended in the body of the book, and a full bibliography and index completes it.

### Medical News.

#### Dublin Sanitary Association.

At a meeting of the Dublin Sanitary Association, held on August 29th, the following resolution was unanimously adopted:—"That the Council of the Dublin Sanitary Association view with concern the great prevalence and fatality of diarrhoeal diseases among very young children in Dublin at present, and urge upon the parents of children resident in tenement houses the necessity for great care in the preparation of the food

intended for young children. The Council advise those parents to apply to the Public Health Office, Cork Hill, or at one of the city dispensaries for information as to the preparation and keeping of infants' food." The Council then adjourned.

#### Vital Statistics.

THE deaths registered in the week ending August 24th in 36 large towns of Great Britain and Ireland corresponded to an annual rate of 21.3 per 1,000 of their aggregate population, which is estimated at 11,463,026 persons in the middle of this year:—

Birkenhead 26, Birmingham 27, Blackburn 23, Bolton 20, Bradford 19, Brighton 19, Bristol 14, Burnley 17, Cardiff 14, Croydon 16, Derby 18, Dublin 24, Edinburgh 17, Glasgow 18, Gateshead 30, Halifax 17, Huddersfield 14, Hull 27, Leeds 24, Leicester 24, Liverpool 22, London 19, Manchester 26, Newcastle-on-Tyne 28, Norwich 21, Nottingham 23, Oldham 26, Plymouth 18, Portsmouth 21, Preston 21, Salford 27, Sheffield 25, Sunderland 29, Swansea 27, West Ham 22, Wolverhampton 21. The highest annual death-rates per 1,000 living, as measured by last week's mortality, were:—From measles, 1.9 in Birkenhead, and 2.5 in West Ham; from scarlet fever 1.1 in Wolverhampton and 1.2 in Blackburn; from whooping-cough, 1.7 in Swansea; and from diarrhoeal diseases, 8.7 in Nottingham, 8.8 in Birmingham, 9.3 in Sheffield, 9.7 in Newcastle-on-Tyne, 10.1 in Salford, 10.4 in Manchester, 10.8 in Hull, 11.0 in Sunderland, and 14.6 in Gateshead. In none of the large towns did the death-rate from "fever" reach 1.0 per 1,000. The 58 deaths from diphtheria included 27 in London, 6 in Leicester, and 4 in Salford. No death from small-pox was registered in any part of the United Kingdom.

#### The Mortality in Foreign Cities.

THE following are the latest official returns, and represent the last weekly death-rate per 1,000 of several of the populations:—Calcutta 51, Bombay 50, Madras 47, Paris 15, Brussels 14, Amsterdam 14, Copenhagen 25, Stockholm 18, Christiania 22, St. Petersburg 23, Moscow 23, Berlin 24, Hamburg 25, Breslau 36, Munich 20, Vienna 17, Prague 21, Buda-Pesth 16, Rome 20, Venice 20, Philadelphia 19.

#### The Chemists' and Druggists' Exhibition.

FOR the last seven years an annual Exhibition of Manufacturing Chemists and Druggists has been organised by the proprietors of our contemporary, the *British and Colonial Druggist*, that for the present year being held at the London Opera House during last week, and, judging by the number of exhibitors, it is evidently appreciated by a large section of the wholesale trade. Although exhibitions as a whole have been considerably overdone, and one is moreover very much like another, a good deal may be said in favour of a gathering of this nature, whereat manufacturers and importers bring their goods together under one roof and invite the retail chemists to come and inspect; the two branches are thus brought into personal contact, one might hope with mutual advantage. Few of the large houses were, however, represented on the present occasion, and one missed such well-known firms as Allen and Hurbury's, Burroughs and Wellcome, Martindale's, Southall's, Savory and Moore, Squire's, etc. The limited capacity of the building may, however, be in some measure accountable for this apparent want of interest. American houses were fully represented, Messrs. Parke Davis, the Merrell Chemical Co., Messrs. Warner and Co., Messrs. Stiles and Son, and the Abbey Effervescent Salt Co., &c., having large shows. Sponges, perfumery, soaps, and disinfectants were strongly in evidence, whilst cure-alls and pick-me-ups were to be had for the asking. Of the more serious British exhibits those of Messrs. Newbery and Sons, Thos. Christy and Co., Price's Patent Candle Co., Vinolia, Limited, Messrs. St. Dalmas and Co., Messrs. Wyleys of Coventry, the Somatose Co., the Sanitas Co., Bovril and Virol, Limited, and Messrs. Ingram and Royle may be mentioned as excellent representatives of home products, whilst the lighter portion of the programme was filled in by an up-to-date ladies' orchestra.

(a) "Manual of Diseases of the Ear, including those of the Nose and Throat in relation to the Ear, for the Use of Students and Practitioners of Medicine." By Thomas Barr, M.D. Third Edition revised, partially rewritten. Glasgow: James Maclehose and Sons. 1901. Pp. xxiii. and 429. Illustrations 236.

## Notices to Correspondents, Short Letters, &c.

**CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *distinctive signature* or *initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

**REPRINTS.**—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the publisher or printer before the type has been distributed. This should be done when returning corrected proofs.

**ORIGINAL ARTICLES** or **LETTERS** intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication, but as evidence of identity.

### SUGGESTED COLLECTIONS FOR MEDICAL BENEVOLENT FUNDS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—On or about St. Luke's Day the members of the Guild of St. Luke hold their annual meeting, and have an anniversary service at St. Paul's Cathedral. I beg to suggest that a similar service be held in every town in the kingdom on that day or the following Sunday, and that a collection be taken at each, of which one-fifth be given to the British Medical Benevolent Fund, one-fifth to the R.M.B. College, Epsom, one-fifth to the Society for the Relief of Widows and Orphans of Medical Men, one-fifth to the Lancashire Relief Fund, and one-fifth to church expenses. &c. These most deserving charities would benefit greatly by these collections. St. Luke's Day, Oct. 18th, will this year fall on a Friday.

I am, Sir, yours truly,  
HORACE E. HAYNES.

**OUR PARIS CORRESPONDENT.**—Translation of the Clinical Lecture on "Vomiting in Pregnancy" was delayed in post, but has now come to hand.

**DR. HY O'HARA** (Melbourne).—Your interesting case of "Total Gastrectomy for Carcinoma of Stomach" has been received, and will appear in an early number.

**DR. W. W.**—It is hardly worth while calling attention to the matter unless correspondence should result. The explanation is obvious, we imagine.

**PATERFAMILIAS** The Scotch and Irish schools open somewhat later than those in England. You will find fees and relative cost of curriculum in our "Educational Number," to be published next week.

### PROF. ROBIN ON THE TREATMENT OF CANCER OF THE STOMACH.

A CORRESPONDENT having read the "Paris Clinical Lecture" on this subject in our issue of August 21st, and having much interest therein, wrote us that it was of extreme importance, but that there appeared to be a little discrepancy in the dosage. We thereupon referred the letter to our Paris correspondent who furnished the lecture, and append his reply, as it may be of interest to other readers also. He says:—

"There were evidently some slight errors, which may have been my fault in rapid translation or that of the printer. In any case, I proceed to correct them as follows, giving the exact copy of Prof. Robin's formulae:—

Persulfate de soude ... 1 gramme.  
Eau ... 150  
Une c. à café avant les deux principaux repas.  
Méla vanadate de soude ... 0'03 centigr.  
Eau ... 150  
Une c. à café avant les deux principaux repas.

Your correspondent can convert these figures himself, remembering that

One centigramme equals 0.15432 grains.  
One gramme equals 15.432 grains.  
One ounce equals 28.3495 grammes.

I am always very particular about formulae, but it would be invidious to state fractions of ounces and grains. For instance, one grain ought to represent five centigrammes, while in reality it is seven centigrammes. Ounces, drachms, scruples, &c., constitute an anachronism to-day. The French metric system ought to be adopted everywhere. It is much easier."

### Appointments.

**EMINSON, L.**, L.F.P.S.Glasg., L.S.A., District Medical Officer of Cosford Union.  
**FORBES, N. HAY**, F.R.S.Edin., J.P., Honorary Consulting Surgeon to the Black Rock Convalescent Hospital, and Consulting Surgeon to the Rother Valley Railway Company.  
**LAING, C. F.**, M.B., C.M.Glasg., Medical Superintendent to the Somerset and Bath Asylum.  
**MILES, H. P.**, M.R.C.S. L.R.C.P.Lond., District Medical Officer of Kingsbridge Union.

### Vacancies.

**British Medical Temperance Association.**—Assistant Secretary. Must be a qualified practitioner, a total abstainer, and able to speak in public. Salary £150 per annum, with lecture fees and board and residence. Applications to the hon. sec., Dr. Ridge, Carlton House, Enfield. (See advt.)

**Birmingham and Midland Ear and Throat Hospital**, 109, Edmund Street, Birmingham.—House Surgeon. Salary at rate of £40 per annum for first six months, and if re-appointed, at rate of £60 per annum, with board, lodging, and washing.  
**Cheeshire County Asylum**, Parkside, Macclesfield.—Junior Assistant Medical Officer, unmarried. Salary £130, rising to £150 per annum, with board, apartments, washing, and attendance.  
**City of Nottingham Workhouse Infirmary.**—Assistant Medical Officer. Salary £160 per annum, with furnished rooms.  
**Cornwall County Asylum**, Bodmin.—Junior Assistant Medical Officer, unmarried. Salary £120, rising to £150, with board, furnished apartments, &c.  
**County Asylum**, Lancaster.—Assistant Medical Officer, unmarried. Salary £150, increasing to £200, with apartments, board, washing, and attendance.  
**East Riding of Yorkshire.**—County Medical Officer of Health. Salary at rate of £400 per annum, rising to £500 per annum, with allowances. (See advt.)  
**Glamorgan County Asylum**, Bridgend.—Assistant Medical Officer, unmarried. Salary £175, with board, lodging, attendance, and laundry.  
**Glasgow University.**—Additional Examinership in Medicine and Science. Annual emolument £30. Duties to commence in January, 1902. (See advt.)  
**Great Northern Central Hospital**, London.—Vacancies for House Physician. Salary £60 per annum; Junior House Physician, Salary £30. Board, residence, and washing provided in each case. Also Junior House Surgeon, Salary £30, with board, residence, and washing; and a non-resident Assistant House Surgeon, with Salary at rate of £30 per annum, and partial board. Full particulars of these vacancies will be found in our advertisement columns.  
**Kaar-el-Ainy Hospital and School of Medicine**, Cairo, Egypt.—Physician to the Hospital and Professor of Clinical Medicine at the School. Salary £E320 per annum and private practice allowed.  
**Manchester Children's Hospital.**—Junior Resident Medical Officer, unmarried, for six months, and eligible for election as Senior for another six months. Salary at rate of £80 a year when Junior, and £100 a year as Senior, with board and lodging.  
**North Wales Counties Lunatic Asylum**, Denbigh.—Second Assistant Medical Officer. Salary £120 per annum, rising to £160, with board, residence, and washing.  
**Owens College**, Manchester. Junior Demonstrator in Physiology. Salary £100, rising to £150 per annum.  
**Royal South Hants and Southampton Hospital.**—Junior House Surgeon for first six months. Salary at rate of £50 per annum, with rooms board, and washing.  
**Salford Royal Hospital.**—House Surgeon, salary, £100 per annum; House Physician, salary £80 per annum; and Junior House Surgeon, salary £70 per annum, with board and residence in each case.  
**Swansea Union Workhouse.**—Assistant Medical Officer. Salary £200 per annum.

### Births.

**BOXALL.**—On August 26th, at Portland Place, London, W., the wife of Robert Boxall, M.D.Cantab., of a daughter.  
**GILLESPIE.**—On August 31st, at 12, Walker Street, Edinburgh, the wife of A. Lockhart Gillespie, M.D., F.R.C.P.E., of a daughter.  
**JOSCELYNE.**—On August 26th, at The Homestead, Southwick, Sussex, the wife of E. W. Joscelyne, M.B.Durh., of a son.  
**MATTHEWS.**—On August 27th at Holly Lodge, Crawley, the wife of Sidney Matthews, M.R.C.S.Eng., L.R.C.P.Lond., of a son.  
**WIELD.**—On August 29th, at Wickham Terrace, Brisbane Queensland, the wife of David Wield, M.D., of a daughter. (By cable.)

### Marriages.

**GUTCH—METCALFE.**—On August 27th, at St. Michael's Church, Sutton, Wansford, Northants, John Gutch M.D.Cantab., of Ipswich, eldest son of the late John James Gutch, of Holgate Lodge, York, to Dorothy Emily, second daughter of the late Frank Metcalfe, of Mote House, Wisbech, and of Mrs. A. Metcalfe, Manor House, Sutton.  
**NEWSOME—GIBBS.**—On August 22nd, at St. Stephen's Church, Redditch, Herbert Newsome, M.B., F.R.S.Durh., late R.N., to Christine Margarite, youngest daughter of William Gibbs, Esq., Crossies, Redditch.  
**SULLIVAN—DUNCAN.**—On August 27th, at St. Katharine's Church, Bow, P. Sullivan, L.R.C.P., L.R.C.S., &c., of Campbell Road, Bow, to Janet Blanthorne, younger daughter of Captain Robert Duncan, of the R.E.M.S. *Kinfauns Castle*, and of Forest Gate.

### Deaths.

**BUCKLEY.**—On August 26th, at Linden Gardens, Kensington, Henry Child Buckley, M.B., M.S.Aberd., J.P., aged 57 years.  
**COLTART.**—On August 28th, at the Grange, Ruthin, Wales, Charles H. R. Coltart, eldest son of William Coltart, L.R.C.P., M.R.C.S., of Epsom, aged 30 years.  
**KELLY.**—Suddenly, on August 18th, Adam Lawson Kelly, M.D., F.F.P.S.Glasg., aged 66 years, of 26, Blythwood-square, Glasgow.  
**LAWRENCE.**—On August 30th, suddenly, whilst on a holiday in Devonshire, Alfred E. Austin Lawrence, M.D.Aberd., M.D.C.M., of Clifton, Professor of Midwifery and Diseases of Women in University College, Bristol.  
**LIVETT.**—On August 21st (the 87th anniversary of his birth), at Wells, Somerset, Henry William Livett, M.D., L.R.C.P.Edin.  
**TUKE.**—On August 26th, at 39, Drayton Gardens, South Kensington, very suddenly, John Henry Tuke, M.R.C.S., L.S.A., formerly of Week St. Mary, Stratton, Cornwall.

# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXIII.

WEDNESDAY, SEPTEMBER 11, 1901.

No. 11.

## EDUCATIONAL NUMBER, 1901—1902.

### INTRODUCTORY REMARKS.

In the present number will be found a synopsis of the information likely to be useful to those who intend to enter upon the study of medicine, and to serve as a guide to parents and guardians upon whom devolves the responsibility of selecting, not only a particular school, but also a plan of campaign in general. The decision must necessarily be largely influenced by the student's means by his aptitude for study, and by individual circumstances, in so far as they bear on his future career. It is not always possible to determine at that early stage what particular line of practice is to be aimed at. The great thing to compass is a thorough knowledge of the subjects which form the basis of medical education, leaving it to circumstances to settle the question whether general practice or some more specialised department is to be followed.

One point, however, must be settled at the very outset, under penalty of losing much valuable time, viz., whether the student is to content himself with an ordinary license to practise medicine or whether he will aim at university graduation. As years pass by students display more marked appreciation of the advantages which the possession of a university degree unquestionably offers, but there will always remain a large proportion who are constrained to be satisfied with a mere license by reason of a comparatively low standard of preliminary education or because, for pecuniary reasons, they desire to obtain the right to practise at the earliest possible moment. Having made up his mind which course he will pursue the next step is

#### THE CHOICE OF A SCHOOL.

The difference in the amount of the fees exacted by the various medical schools is hardly such as to make the choice of a school a matter to be decided merely by reference thereto. In many instances the choice will be determined by heredity, so to speak, that is to say, by the fact that the student's father or friends has or have been previously associated with a particular school. A more judicious choice may be made by considering the neo-student's intellectual calibre. In a large school he will be subjected to more severe competition, but, as a set-off to this, the prizes are more valuable, and the experience gained in certain respects more comprehensive. Moreover, he is brought into contact with a larger number of those who have attained eminence in their profession, and he makes a larger number of acquaintances as fellow students. In the smaller schools, on the other hand, he comes into far more intimate contact with his teachers, who consequently take a keener interest in his subsequent career. The chances

of obtaining resident appointments at the close of his student career are greater than in the larger schools where the competition for such posts is very sharp, and as dresser and clerk his opportunities for obtaining practical experience are often greater than in the large schools where the number of students is out of proportion to the number of beds. We need not allude here to the possibility of gaining an entrance scholarship, of which there are usually several at most medical schools, because the examinations have already been held.

#### THE CHOICE OF A QUALIFICATION.

While all qualifications nominally confer equal rights in regard to medical practice the selection is fraught with consequences of exceeding gravity. The public, no doubt with some reason, accord special importance to a medical degree as compared with a mere license to practise, so that it is desirable, within the limits of the possible, for the student to aim at obtaining a degree. Apart from this, there are certain qualifications which confer special privileges; for instance, no one can hold an appointment in any of the larger hospitals without being a Member or Fellow of the Royal College of Physicians or Fellow of the Royal College of Surgeons. This is a relic of bygone times, but it still holds good, and has to be borne in mind. The Membership of the Royal College of Physicians is a trying ordeal, not so much by reason of the high standard of knowledge required as of its uncertainty. It is well not to enter the lists until some years have elapsed since qualification. The Fellowship of the College is conferred by a kind of "selection by election," and the selection is made on grounds often quite foreign to professional attainments. The Fellowship of the Royal College of Surgeons, on the other hand, is obtained almost exclusively by examination. All that is required is a high standard of knowledge, both theoretical and practical. Although the possession of the licence of the Apothecaries' Society as a single qualification is looked at askance, even in general practice, it is often useful in order to qualify for a resident appointment pending the student's subsequently obtaining a degree. It must not be forgotten, moreover, that the nature of the qualification is an all-powerful factor in competing for public appointments, to obtain which will be the aim of so many students when prepared to launch forth.

Apart from the resident appointments in the general hospitals there are a large number of appointments available in special hospitals, where experience of a useful kind is to be obtained. These, it is true, lack the social charms of residence in large hospitals where the resident officers are numerous, but, on the other hand

they present advantages which the others do not offer and which cannot fail to favourably influence the practitioner's subsequent career. We do not advise these appointments being taken immediately after qualification with the object of paving the way to taking up a speciality. It is an old maxim that no man should become a specialist until he has had some years experience in general practice.

Consultant rank is only to be obtained by long service and tedious waiting. Apart from the special qualifications which the consultant must possess he has to climb the ladder of promotion in competition with a crowd of rivals, and it will be many years before he can reach the point at which he may hope to reap the fruits of his labours.

#### THE PUBLIC HEALTH SERVICE.

Under existing circumstances the public health service offers plenty of scope for intelligence, tact, and activity. Those only are eligible for any important post in the service who are provided with a diploma in State Medicine. This diploma cannot be obtained for at least two years after qualification, and it entails a somewhat arduous course of study, both theoretical and practical. These appointments, which are determined by election, are under the disadvantage of a certain insecurity of tenure in that they are made for a term of years, usually three. To men possessed of the requisite energy and scientific spirit the position of medical officer of health offers exceptional opportunities for carrying on scientific investigations, and success in this department may pave the way to an appointment under the Local Government Board, though this department of the service is by no means exclusively recruited from among medical officers of health. In addition to a fairly liberal salary these appointments carry the right to a pension after a certain period of service. We would point out the advantage to all students of obtaining the special diploma in State Medicine. Not only is the knowledge thus acquired of extreme utility in practice, but it may prove of inestimable value in later life under circumstances which cannot always be foreseen. Once engaged in general practice the difficulties in the way of obtaining it are well nigh insuperable.

#### THE SERVICES.

Under the head of "The Services" we include the Army, the Navy, the Indian and the Colonial Services. For the time being these outlets fail to attract their quota of the newly-qualified, owing to circumstances into which we need not enter. No better evidence of this is needed than the fact that at the last competitive examination not a single candidate entered for either the Army or Navy. Students therefore will do well to hesitate before they decide on joining one or either of them. The quasi-impossibility of filling the *cadres* will doubtless induce the Government to reconsider the terms and conditions under which candidates are invited to compete, and then the Services may once again prove an attraction to many young medical men. The nomad existence which these posts entail is of itself a great drawback and to some extent the routine work tends to unfit fit men for general practice. These, however, are probably not the reasons which tend to create a prejudice against the Services which indeed is based rather on the unsatisfactory nature of the position *per se*.

#### THE COURSE OF STUDY.

There is so much work to be got through in the present-day curriculum that the student will find it absolutely necessary to be methodical in his studies. He will have to plan out his day with attendance at lectures, practical work at dissection, laboratories, or in wards, and so many hours reading. At the same time he will find it well to keep up regular exercise by walking, cycling, cricket, tennis, rowing, football, and other athletic games. Those who enter in the Winter Session will devote most of their attention to anatomy and physiology, and it will be found greatly to their interest to have got rid of the preliminary scientific work—chemistry, physics, and biology—before entering the medical school. Anatomy and physiology form two of the most essential bases of study, and on the thoroughness with which they are handled will depend much of the success of the student's subsequent career. The importance of practical work in the dissecting-room can hardly be over-rated, and we are fain to endorse the protest which has been raised against the modern tendency to scamp actual dissection in favour of book work with text-books and atlases. The study of anatomy affords a valuable training to the mind, as well as furnishing information that is of daily use in the practice of after life, to say nothing of the manual skill and dexterity that is acquired by careful dissection.

#### THE WARDS.

After the student has passed the examination in anatomy and physiology at the end of the second academical year his transfer to the wards of the hospital will come as a pleasant change. That will be his first entrance into the arena where medical science is ever carrying on the war against disease and death. In the wards it will be his privilege step by step to unravel the tangled threads of the history of each patient, and from the careful collection and examination of facts to arrive at the systematic conclusion known as diagnosis. This period of a student's life is big with possibilities both for good and for evil. It is then that he will lay the foundation of his future grasp of the principles that lie at the root of his profession, a competent knowledge of which can be gained only by careful and conscientious attention to

#### CLINICAL WORK.

This may be called the corner-stone of medical education. In each patient brought under his notice the student has the means of acquiring practical knowledge, but the value of the opportunity depends absolutely on his ability and his willingness to observe. It may be said that all science is observation, and it is certainly true that the chief end and aim of all clinical training is to teach the student how to observe. The difference between a trustworthy and an untrustworthy practitioner lies mainly in the fact that the former has learnt how to test his observations in such a way as to arrive at the truth. This faculty is one that can be acquired by systematic training, which in its turn mainly consists in taking an accurate and faithful record of clinical cases. The habit of careful observation is one which becomes a second nature to the individual who has once become its possessor.

#### THE POST-MORTEM ROOM.

We would strongly advise every student to spend as much time as possible during the last three years of his



studies in the post-mortem room. The post-mortem room is the natural complement of the clinical wards, it is often only in this room that the clinical problem is unravelled, it is there that the student can see for himself the physical results of the processes of disease which he has been watching at the bedside. He learns too, as he can never learn in the dissecting room, to recognise the post-mortem appearances of the various viscera, and to distinguish between changes due to decomposition and those caused by the ravages of disease. The lack of this familiarity has over and over again led to errors of the gravest kind, errors which have had for effect to jeopardise the administration of justice and perchance to place innocent persons in the most serious predicaments.

#### POST-GRADUATE INSTRUCTION.

The earnest student will soon recognise that his five years' training do little more than to fit him to carry on the acquisition of knowledge under favourable conditions. Woe to the man who conceives that he has done all that is required of him when he has obtained the right to practise! The need for further opportunity for study, so generally felt of late years, has found expression in the provision of multiple facilities for post-graduate study. At many of the larger hospitals post-graduate classes have been instituted for the benefit of practitioners who are desirous of remedying the lapsus of medical education, and in London an admirably organised institution—the Polyclinic—is now in full working order, and renders immense service to those who are fortunate enough to be able to avail themselves of its advantages. We would urge upon practitioners the importance of belonging to some local medical society which has the advantage of bringing them into personal contact with their fellow practitioners, and of generalising the knowledge which each individual practitioner has gleaned.

#### THE PRACTICE OF MEDICINE.

To those possessed of the proper spirit and who are equipped with the requisite knowledge, the practice of medicine is not only the means of gaining a livelihood, it is also a congenial and interesting occupation. It brings a man into contact with all classes of society on terms of quasi-equality, and affords unlimited scope for the cultivation of the noblest qualities of humanity. The duty of the practitioner is two-fold—he has a duty to the public and a duty to his profession. His attitude towards his fellow practitioners should be characterised by the courtesousness due to a labourer in the same field, and he should studiously avoid all possible sources of friction. It is an immense advantage to be personally acquainted with one's fellow practitioners in the district, for, as it has been aptly observed, every man is an enemy until you know him. The code of medical ethics in reality does not go further than to enjoin our acting towards others as we would have them act towards ourselves. Any infringement of this code recoils upon the delinquent who thereby forfeits the esteem of his fellows, and, though he may not believe it, the respect of the public. Lastly, all should remember that they are members of an honourable profession, whose traditions should command respect.

#### FOREIGN DIPLOMAS—PRACTICE ABROAD.

The principle of reciprocity of medical practice has

at last been formally recognised by the Privy Council directing the admission of medical graduates of Italian universities to practise in this country subject to recognition by the General Medical Council. In virtue of this agreement, certain, or rather uncertain, facilities are conceded to British practitioners to practise medicine in Italy. The exact terms have not as yet been made public, but in all probability it would suffice to make application to the proper Government department to obtain permission to practise in that country, though as matters stand that right only extends to attendance on the fellow countrymen of the practitioner.

In France the difficulties of obtaining the right to practise have been considerably enhanced of late years; indeed, measures are contemplated which would have for effect to exclude foreign students from pursuing their studies in Paris altogether on the ground that the faculties are already overcrowded. A modified degree is conferred upon foreign students on certain conditions, but this does not carry the right to practise, so that it possesses a merely decorative value. To obtain the right to practise medicine within the territory of the French Republic the student must pass the matriculation examination (baccalauréat), and go over exactly the same ground as the native student, and no exemption from any part of the course of study or examinations is now accorded. The curriculum in France nominally extends over four years, but in practice it extends to five and even six years. The details can be obtained on application to the Dean of the particular university selected.

#### LONDON SCHOOLS.

The Schools of Medicine in the Metropolis are the following, the scholarships, prizes, students' appointments, fees, &c., being set forth in connection with each place named. The names of the hospital staff, lectures, residential terms, and detailed information will be found, as a rule, in our advertisement columns.

**ST. BARTHOLOMEW'S HOSPITAL.**—This hospital has 750 beds, and for many years past the school attached has had a larger number of entries than any other medical school in London. Collegiate residence is here permissible, subject to the ordinary rules. The recreation ground for the use of students is at Winchmore Hill.

**Appointments.**—Ten house physicians and ten house surgeons are appointed annually. During the first six months of office they act as "junior" house physicians and house surgeons, and receive a salary of £25 a year. During their second six months they become "senior" house physicians and house surgeons, and are provided with rooms by the hospital authorities, and receive a salary of £80 a year. A resident midwifery assistant and an ophthalmic house surgeon are appointed every six months, and are provided with rooms and receive a salary of £80 a year. Two assistant anaesthetists are appointed annually, and receive salaries of £120 and £100 a year respectively. An extern midwifery assistant is appointed every three months, and receives a salary of £80 a year. Two assistant electricians are appointed every six months, and in-patient dressers, in-patient clinical clerks, clerks and dressers to the assistant physicians, and to the physicians and surgeons in charge of special departments are appointed every three months without fee.

**Scholarships, &c.**—There are four open scholarships in science, £75, £75, £150, £50, tenable for one year, and a Jeaffreson exhibition, value £20; four junior scholarships of £80, £25, £20 and £10, respectively; Treasurers'

prize for practical anatomy; Foster prize in practical anatomy; senior scholarships, value £50, for anatomy, physiology, and chemistry; Wix prize, Hichens prize, Lawrence scholarship and gold medal, value 40 guineas, for medicine, surgery, and midwifery; two Blakenbury scholarships, of £39, in medicine and surgery; Bentley prize, for reports of surgical cases; the Kirkes gold medal for clinical medicine, with scholarship of £30. Shuter scholarship of £50; Skynner prize of £15; Sir G. Burrows' prize of £10 and Matthews Duncan medal and prize, value about £20; the Treasurer's Research Studentship, of the value of £100, is given annually, the elected student being required to engage in original research in pathology.

*Fees.*—Fees for perpetual attendance on lectures and hospital practice, 160 guineas, payable in the following instalments:—First year, 40 guineas; second year, 40 guineas; third year, 40 guineas; fourth year, 40 guineas; or a single payment of 150 guineas. Fee for general subjects for students of dental surgery: First winter, 31½ guineas; first summer, 31½ guineas, or a single payment of 63 guineas. Fee to University students, 80 guineas; fee for laboratory instruction for D.P.H., 20 guineas; composition fee to University of London students for one year's instruction for the Preliminary Scientific Examination, 20 guineas. Composition fee to University of London students who have passed the preliminary scientific examination, 150 guineas.

The Warden, Dr. James Calvert, will furnish further details on application.

**CHARING CROSS HOSPITAL.**—The school attached to this hospital is situated in central London, and contains new physiological, pathological, and bacteriological laboratories, *materia medica* museum, an anatomical theatre, enlarged dissecting-room, and chemical theatre. The hospital, which is now being enlarged, contains 180 beds, making, with the 30 beds at the adjoining Royal Westminster Ophthalmic Hospital (to the practice of which general students are admitted free) a total of 210 beds available for clinical study.

Clinical instruction is given in medicine, surgery, and obstetrics, and in the special department, diseases of the skin, diseases of children, mental disorders, the throat, the nose and ear, and in the orthopedic, Röntgen, and electrical departments.

*Scholarships, Medals, &c.*—Five entrance scholarships, the Livingstone scholarship, 60 guineas, and 55 guineas; Huxley scholarship, 40 guineas and 30 guineas. Three (100 guineas, 60 guineas, and 40 guineas) are open to all general students, one (55 guineas) is reserved for the sons of medical men, and one (30 guineas) is open to dental students only. All are awarded annually. Two Universities scholarships, value 60 guineas each, are open to students from the University of Oxford who have passed the 1st M.B., to students of the University of Cambridge who have passed the 2nd M.B., and to students of the University of London who have passed the intermediate examination in medicine. Candidates must give notice to the librarian of their intention to compete on or before September 21st, 1901. The Golding Prize of £10 is open to students at the end of their first winter session. The Huxley Medal, with prize of £10, is open to students at the end of their second winter session. The Pereira Prize of £5 is open to all general students. The Llewellyn Prize of £25 is awarded annually at the end of the curriculum. The Governors' Clinical Gold Medal is also open to students at the end of their curriculum, and a silver medal or its equivalent in books, is awarded to the most distinguished student in each class.

*Appointments.*—The curator and pathologist is appointed annually, and receives £100 a year; medical and surgical registrars to the hospital receive £40 a year each, with luncheon in the hospital; obstetric registrar, six house physicians, six house surgeons, and two resident obstetrical officers are appointed each year; clinical clerks, dressers, and surgical ward clerks are appointed in all the general and special departments of the hospital.

*Fees.*—For the curriculum of study required by the various examining bodies and hospital practice, 110 guineas in one sum, or 121 guineas in five instalments.

The composition fee for sons of registered medical practitioners is 110 guineas, and the fee by instalments, 121 guineas. For dental students, 54 guineas in one sum, or 60 guineas payable in two instalments.

**ST. GEORGE'S HOSPITAL.**—This hospital is situated in a favoured position in the West End, facing Hyde Park. It contains 350 beds, and special wards for ophthalmic cases and diseases of women.

*Appointments.*—Four house physicians and four house surgeons, entitled to reside and board in the hospital free of expense; two assistant house physicians, two assistant house surgeons, four assistants in the special departments. Candidates for the above offices are selected quarterly by competition from among the perpetual pupils, and hold all the offices in succession during a period of two years, sixteen pupils being in office at any one time. Obstetric assistant with a yearly salary at the rate of £100 and board and residence in the hospital; pathological curator with a salary of £100; assistant curator with a salary of £50; two medical registrars, with salaries of £50 and £30 per annum; a surgical registrar with a salary of £50 per annum; an administrator of anaesthetics with a salary of £50 and two with salaries of £30 per annum; a surgery officer with a salary of £100 a year; three demonstrators of anatomy with a salary of £50 each; and assistant demonstrators. All offices are open to candidates without additional fee.

*Exhibitions, &c.*—The Brown exhibitions, one of £100 per annum, tenable for two years, and open to perpetual pupils possessing a registrable diploma; and one of £40 per annum, tenable for three years and open to students in their third year. The Braekenburg prizes of the value of £40 each, one each in medicine and surgery. The Webb prize in bacteriology, value £30. The Clarke good conduct and clinical work prize in surgery, the Thompson medal, the Brodie clinical prize in surgery, the Acland clinical prize, the Johnson prize in anatomy, the Pollock clinical prize in physiology, the Treasurer's prize for clinical reports, and four general proficiency prizes of ten guineas each.

*Scholarships.*—One in arts of £150 for sons of medical men who have entered the school during the current year. Two in arts of £50, open to commencing students, and a further scholarship in arts of £50 to sons of officers of His Majesty's service, who have met their death by serving in the South African campaign. Examination, September 24th. Two of £35 in anatomy and physiology, open to students who have signed up for or passed the first M.B. Oxford or second M.B. Cambridge. One of similar value for students of Provincial University colleges of similar standing. Examination, September 24th.

*Fees.*—Composition fee for perpetual pupils, £150, or £160 in the following instalments: First year £50, second year £50, third year £40, fourth year £20. The fee for general subjects in dental surgery is £55, payable in two instalments: first year £30, second year £25. Only perpetual pupils can hold house office or compete for the Brown exhibitions.

**GUY'S HOSPITAL.**—This hospital is situated on the Surrey side of London Bridge, and contains 554 beds with special wards for ophthalmic and obstetric cases. Attached to the hospital is a large residential college with rooms for about sixty men, whilst for students who prefer to live in the suburbs, no other hospital is so conveniently placed, the railway accommodation being good and close at hand. There is now a complete School of Dental Surgery at this Institution, which is recognised by the Royal College of Surgeons of England, the facilities thus afforded of completing the whole course of dental study within the walls of one hospital will be appreciated by those intending to practise dentistry.

*Re-opened Ward.*—One of the wards which have for many years been closed for want of funds was re-opened in October, 1898, as a special ward for diseases of women, eight beds being set apart for difficult cases of labour. An obstetric registrar and tutor and an ophthalmic registrar and tutor have been appointed to augment the teaching in the special departments.

*Appointments.*—Eight house surgeons, eight house physicians, eight assistant house physicians, twenty-four

assistant house surgeons, eight obstetric residents, twenty-four clinical assistants, and ninety-six dressers are selected annually from the students according to merit, and without payment. There are also a large number of junior appointments, every part of the hospital practice being systematically employed for instruction.

**Scholarships.**—Open scholarships of £100 or £50 in classics, mathematics, and modern languages. Open scholarships of £150 and £80 in chemistry, physics, and biology, and an open scholarship of £50 for University students in two of the following subjects:—Anatomy, physiology, organic chemistry, zoology, physics. Six scholarships, varying in value from £13 to £25 each, for general proficiency in medical study, open to students of different years. The Treasurer's gold medal in medicine; the Treasurer's gold medal in surgery; the Sands Cox scholarship of £15 per annum for three years for physiology; the Michael Harris prize of £10 for anatomy; Beaneys prize in pathology, 30 guineas; the Beaneys scholarship in materia medica, 30 guineas; the Golding-Bird gold medal and scholarship (£20) for sanitary science; and the Gull Research scholarship of £150 per annum. The Physical Society awards two prizes, each of £5, to the authors of the best essays on selected subjects, prizes of £10 and £5 for the best papers read before the Society, and a prize of £5 to the member who has most distinguished himself in the debates of the session.

**New School Buildings.**—A considerable addition to the school buildings was opened in 1897, comprising a series of class-rooms, laboratories, and a lecture theatre for the teaching of physiology.

**Fees.**—For the entire course of lectures and hospital practice, 150 guineas, if paid in one sum on entrance; or payment may be made by four instalments of 40 guineas each, payable at the beginning of the first, second, third, and fourth years respectively.

**KING'S COLLEGE HOSPITAL.**—This hospital is centrally situated, being contiguous to the Royal College of Surgeons, Lincoln's Inn Fields. The College adjoins Somerset House, and is close to the hospital, in which there are 220 beds available for clinical teaching; ophthalmic, ear, throat, skin, and dental departments, are attached to the hospital. Some wards are specially devoted to children's diseases. The wards have been recently refloored and the electric light installed throughout.

**Scholarships.**—£800 are awarded annually in scholarships and prizes. At entrance two science exhibitions of £60 and £40 value are open to all candidates under the age of nineteen; two scholarships of the value of £75 each (subjects literary) and two exhibitions of the value of £60 and £40 each (subjects scientific) are open to students commencing their curriculum. Two scholarships, value seventy and sixty guineas, are open to students of a British University who come up to London to complete their curriculum; two junior scholarships of £20 each for first year students, one of £30 for second year students, one of £50 for third year students in residence, and one of £40 for fourth year students. In addition students may compete for the Daniell scholarship, value £40; the Warnford prizes, value £40; the Rabbeth scholarship, value £20; the Carter, Todd, Jelf, Tanner, Leathes prizes, and all class and clinical prizes.

**Appointments.**—Medical and surgical Sambrooke registrarships, tenable for two years, each £50 per annum. Resident hospital appointments, viz., senior and junior house physicians, assistant house physician, physician accoucheur's assistant and assistant house accoucheur, and three house surgeons with free board and residence at the hospital; and senior and junior clinical assistants in special departments.

**Residence of Students.**—There are chambers allowing a limited number of students the opportunity of residing at the College.

**University of London.**—Special courses of lectures and practical instruction in the chemical, physical, and physiological laboratories have been arranged for students preparing for preliminary scientific, and

intermediate science examinations of the University of London.

**F.R.C.S. Examinations.**—Special classes are arranged for both the primary and final F.R.C.S. examinations. Further particulars can be obtained from the Dean.

**LONDON HOSPITAL.**—This hospital is the largest in the United Kingdom, containing as it does, 800 beds. It has, moreover, wards and a teaching staff for almost every special department in the domain of medicine: the scholarships and prizes are many and valuable, and both school and staff are deservedly popular with students.

**Scholarships and Prizes.**—At Entrance.—Prize scholarship in science, £120; Prize scholarship in anatomy and physiology, £60; entrance scholarships in science, £80 and £35; Epsom scholarship, £126; Buxton scholarships in arts, £30 and £20. After Entrance.—Anatomy and biology scholarship, £20; anatomy and physiology scholarship, £25; Letheby prize, senior, £20; Letheby prize, junior, £10; scholarship in clinical medicine, £20; scholarship in clinical surgery, £20; scholarship in clinical obstetrics, £20; Duckworth Nelson Prize, £10; Hutchinson prize, £35; Sutton prize, £20; Sir Andrew Clark prize, £26; Anderson prizes, £9; Out-patient dressers' prizes, £60; practical anatomy prizes, £10.

**Appointments.**—The "House" appointments, which are more numerous than at any other hospital in the Kingdom, are made without fee of any kind, and all resident officers are provided with free board and rooms, and in a few instances with a small salary also.

The additional buildings for the department of public health, for the biological, chemical, and physical laboratories, materia medica museum, &c., and the new bacteriological department with general laboratory, research laboratories, class rooms for D.P.H. work, sterilising room, animal room, &c., are now open. For all these departments, special teachers have already been appointed who are devoting their entire time to the particular subjects that they have undertaken. In addition to these alterations and additions, arrangements have been made in the hospital for additional clinical teaching.

**Fees.**—Perpetual fee for lectures, demonstrations, and Hospital Practice, payable in three instalments of 45, 45, and 40 guineas at the commencement of the 1st, 2nd, and 3rd years respectively, 130 guineas; or if in one payment, 120 guineas. A reduction of 8 guineas for chemistry and physics, and 5 guineas for elementary diology is made from the above fees, in the case of students who have passed in these subjects at the First-Conjoint Examination before entering the College. Fee for students entering in their third year (their first and second years having been spent at a recognised medical school elsewhere), 65 guineas. (This fee is payable by students entering who have passed the first M.B. Oxford; the second M.B. Cambridge; or the Intermediate M.B. London.) Dental students (general hospital practice and lectures), 40 guineas. General fee for dental practice, 10 guineas.

**Notes.**—A reduction of 15 guineas will be allowed to the sons of medical men from the perpetual fee if paid in full, or 5 guineas from each instalment.

Special entries can be made either for single courses of lectures for hospital practice.

Accommodation is obtainable at a very reasonable rate close by, or in the suburbs a few minutes' distant by train. Dinners and luncheons are provided in the Students' Club, which, with the reading and smoking rooms, now form part of the college buildings. The "London Hospitals' Club Union" has a field for cricket, football, &c., with an excellent pavilion, at Lower Edmonton. The clubs and societies are open to all the students, and are warmly encouraged by the staff. The new club rooms, gardens, and forecourt are now open. Full particulars of the Warden, Dr. Munro Scott.

**ST. MARY'S HOSPITAL.**—This hospital is situated at Paddington, near the terminus of the Great Western Railway, and at present contains 281 beds. Fresh laboratories, fitted with electric light and all modern improvements, for the study of pathology and

bacteriology, have recently been added, and also a new physiological lecture-room. During the past year a special department of pathological chemistry has been instituted.

*The New Wing.*—The new wing, the ground-floor of which, comprising the new out-patient department, was opened in 1898, is about to be completed. This will add to the hospital 100 new beds, and will include an additional operating theatre, a new clinical laboratory, and an X-ray department.

*Appointments.*—All clinical appointments in the Hospital are free to students of the Medical School, and the resident medical officers are chosen by competitive examination. Six house physicians, six house surgeons, four obstetric officers, and two resident anaesthetists are appointed in each year, and receive board and residence in the Hospital.

*Scholarships, &c.*—One scholarship in natural science, of the value of £145, open to any gentleman who has not completed a winter session of study at a medical school. Two scholarships in natural science, each of the value of £78 15s., and one of £52 10s., under the same conditions. Two scholarships, each of 60 guineas, open to students from the Universities of Oxford and Cambridge. The scholarships will be awarded by examination on September 24th and 25th.

*Fees.*—Fee for attendance on the full five years' curriculum of hospital practice and all lectures, demonstrations, and special tutorial classes, including membership of the Library, Medical Society, Students' Club, and all the athletic clubs, and the receipt of the hospital Gazette for five years, £140 paid in one sum on entering the school; or in instalments, £145

Students who have completed their examinations in anatomy and physiology at the Universities of Oxford, Cambridge, or other University, are admitted as perpetual pupils on payment of a fee of 60 guineas in one sum, or 65 guineas in two annual instalments. University students, prior to completing the anatomy and physiology examinations, pay an annual fee of 25 guineas. After completing the anatomy and physiology examinations, the inclusive fee may be paid.

*Preliminary Scientific Course.*—Special classes, including lectures and laboratory work, are held throughout the year.

**MIDDLESEX HOSPITAL.**—This hospital, which is conveniently situated in the centre both of business and residential London, contains 340 beds. There are special departments for cancer, and for ophthalmic, throat, aurial, skin, dental, and children's diseases. Wards are also devoted to cases of uterine disease and of syphilis. The new school buildings are now in regular use. Residence for students is obtainable in the residential college, which has its frontage on the hospital garden.

*Appointments.*—Casualty surgical officer, casualty medical officer, six house surgeons, six house physicians, and two resident obstetric physicians. The above officers have residence and board in the college free of expense. Clinical clerks and dressers in all the departments are also appointed in addition to the foregoing.

*Scholarships, &c.*—Two entrance scholarships of the value of £100 and £80 respectively. One entrance scholarship of the value of £60, open to Oxford and Cambridge students only. (Subjects—Anatomy and physiology, including histology.) Two Broderip scholarships of £60 and £40 respectively, for medicine and surgery; John Murray medal and scholarship, awarded every third year; the Governor's prize of £21 for students in their final year. Hetley clinical prize, value £25, awarded annually for proficiency in practical clinical medicine, surgery and obstetrics; the Lyell Gold Medal in surgery and surgical anatomy; the Leopold Hudson prize, value 11 guineas, in surgical pathology, including bacteriology; Freeman scholarship, £30, in obstetrics and gynecology; exhibitions of 10 guineas and 5 guineas for anatomy and physiology to second and first year's students respectively, as well as class prizes in all subjects.

*Fees.*—General fee for the entire course of hospital practice and lectures, 135 guineas if paid in one sum on entrance, or by instalments of 60, 50, and 35 guineas,

payable at the commencement of the first, second, and third years respectively. General fee for members of a University who have completed one year of medical study, 80 guineas if paid in one sum, or by instalments of 60 and 40 guineas. For those who have completed their anatomical and physiological studies the fee is 70 guineas on entrance, or in two instalments of 40 and 35 guineas. The composition fee for London University students who have passed the preliminary science examination is 115 guineas. The fee for the curriculum for dental students is 54 guineas on entrance, or two instalments of 40 guineas and 20 guineas.

**ST. THOMAS'S HOSPITAL.**—This hospital, with its medical school attached is one of the schools of the University of London. It is situated on the southern embankment of the Thames, facing the Houses of Parliament, and contains 572 beds, of which about 512 are in use. The school buildings, which are separated from the hospital by a quadrangle, comprise numerous theatres, laboratories, and class rooms, which are well adapted for the modern teaching of large bodies of students in all the subjects of medical curriculum. There is a large library and reading room, and a very complete museum and gymnasium. A ground of more than nine acres in extent is provided at Chiswick for out-door sports.

A clinical laboratory has been recently built, in which all the more difficult methods of diagnosis, bacteriological, chemical, and microscopical, are carried on under the direction of a superintendent. The department for out-patients has been re-arranged, so that large numbers of students are enabled to follow closely the practice and teaching of the assistant staff. To this department there has been added a completely fitted operating room.

Appointments are open to all students. A resident assistant physician and a resident assistant surgeon are appointed annually at a salary of £100 with board and lodging. Two hospital registrars, at an annual salary of £100 each, are appointed yearly. The tenure of these offices may be renewed for a term not exceeding two years. An obstetric tutor and registrar is appointed each year at an annual salary of £50. Four house physicians, two assistant house physicians, four house surgeons, four assistant house surgeons, two obstetric house physicians, two ophthalmic house surgeons, and eight clinical assistants in the special departments are appointed every three months. Clinical clerkships and dresserships to in- and out-patient departments are available to the number of more than 400 each year.

*Scholarships, Prizes, &c.*—Three entrance scholarships are offered for competition in September, viz., one of £150 and one of £80 in chemistry and physics, with either physiology, botany, or zoology at the option of candidates for first year's students; one of £50 open to University students who have passed in anatomy, physiology, materia medica, and pharmacy for a medical degree in any of the Universities of the United Kingdom, and have not entered as students in any London medical school. Copies of the examination papers of last year may be obtained on application to the medical secretary. Applications must be sent in not later than September 17th, with certificate of birth and of preliminary examination, and with a notification as to the optional subject chosen. Numerous scholarships, prizes, and medals are open to competition throughout the whole career of a student, including a Fellowship of £100 given by the Salters' Company for research in pharmacology.

*Fees.*—The fees may be paid in one sum or by instalments. Entries may be made separately to lectures or to hospital practice. Special arrangements are made for students from the Universities and elsewhere entering in their second or subsequent years, also for dental students and for qualified practitioners.

Special classes for the Preliminary Scientific and Intermed., M.B.Lond., for the Oxford and Cambridge examinations, and for the Primary F.R.C.S., are held throughout the year.

A register of approved lodgings is kept by the medical secretary, who has a list of local medical practitioners

and others who receive students into their houses. The prospectus of the school, containing full particulars as to fees, course of study advised, &c., and all necessary information, may be obtained on application to Mr. Bendle, the medical secretary.

**UNIVERSITY COLLEGE HOSPITAL.**—This hospital is situated in Gower Street, not far from Euston Railway terminus. The college where the classes are held faces the hospital, on the opposite side of the street. The number of beds available for teaching purposes is 210.

**Appointments.**—Eight house physicians, six house surgeons, four senior and four junior obstetric assistants, and two ophthalmic assistants, are selected annually by examination from among the senior students, without fee. The house physicians and house surgeons reside in the hospital for a period of six months, and the senior obstetric assistants for three months, and receive their board and lodging free.

The offices of out-patient physicians' and surgeons' assistants, clinical clerks, surgeons' dressers, and ophthalmic surgeons' assistants are filled by pupils who are also students of the college, without additional fee.

**Scholarships, &c.**—Entrance scholarships: One of the value of £120, and two of 55 guineas for proficiency in science, the subjects being those of the Preliminary Scientific Examination of the University of London, and two of 76 guineas each, the subjects being anatomy and physiology; the Atkinson-Morley surgical scholarship of £45 a year, tenable for three years; Atchison's scholarship, value £55, tenable for two years; Sharpey physiological scholarship, value about £110 a year, tenable for three years; Filiter exhibition for proficiency in pathological anatomy, value £30; Erichsen prize, operating case, value £10 10., awarded for practical surgery, Dr. Fellow's clinical medals, the Liston gold medal, Alexander Bruce gold medal, Cluff memorial prize, Tuke medals for pathology, class medals, &c.; gold and silver medals, or other prizes, as well as certificates of honour, are awarded after competitive examinations in particular branches of study. The Tuffnell scholarship of £80 for chemistry, two years; and the Clothworkers' exhibitions in chemistry and physics of £30 each, can also be held in the medical faculty.

**Fees.**—The following have been grouped to meet the requirements of the various examining boards:—1. For the medical examination required by the Examining Board in England and the Society of Apothecaries: 150 gs. if paid in one sum at the commencement of the course; 155 gs. if paid by instalments. 2. For those students who do not require to attend chemistry, pharmacy, and elementary biology at a medical school (under the regulations of the examining board in England) the fee is: 135 gs. if paid in one sum; 140 gs. if paid by instalments. 3. For the courses necessary for the Preliminary Scientific Examinations of the University of London, 25 gs. 4. For the course of instruction for the Intermediate Examination in Medicine of the University of London, 60 gs. paid in one sum. 5. For the course of instruction for the final M.B. examination of the University of London, 80 gs. if paid in one sum; 82 gs. if paid by instalments. This course of instruction is also suitable for the corresponding examinations at the Universities of Oxford, Cambridge, and Durham. 6. Composition fee for dental students, for the courses required for the L.D.S., 65 gs. or exclusive of chemistry, practical chemistry, physics, and *materia medica*, 50 gs. The composition fees, 1, 2, 4, and 5, admit to attendance on systematic lectures and to hospital practice, where this is included in the fee, during five years.

**WESTMINSTER HOSPITAL.**—This hospital is conveniently situated, facing the Abbey, and is readily accessible from all parts of the metropolis. It contains 205 beds for general cases, and all the special departments. New school buildings have been erected close by which afford accommodation for 150 students. The class rooms, dissecting rooms, and lecture theatre are excellent samples of modern erections, affording ample scope for study.

**Appointments.**—Medical and surgical registrars, each

£40 per annum; two house physicians, two house surgeons, two assistant house surgeons, and resident obstetric assistant. These officers, except the two first named, are all boarded free of expense. Fourth year's students are appointed to be clinical assistants in the various departments.

**Scholarships, &c.**—(a) Winter Session.—The Guthrie scholarship £60, entrance scholarship £40, entrance scholarship £30, dental scholarship £20; subjects, Latin, mathematics, experimental physics, chemistry, and either Greek, French, or German. Oxford and Cambridge scholarships, £40 and £30, subject, anatomy and physiology. Natural science scholarship, £60, same as for Prel. Sci. of University of London. Natural science scholarship, £40, chemistry and physics. Free presentation, open to pupils of Epsom Medical College. (b) Summer Session.—Natural science scholarship, £60, same as winter. Natural science scholarship, £40, same as above. Arts scholarship £60, arts scholarship, £40, Oxford and Cambridge scholarships £40 and £30, subjects same as in winter session. (c) Prizes.—Treasurer's, 10 guineas, for first year's men; Chadwick, 20 guineas for students of any year not exceeding fifth. To be competed for by unqualified men. Bird medal and prize, £14, for students who have completed fourth winter session. Sturges prize in clinical medicine £8, clinical surgery prize £5, to be competed for by unqualified men. And class prizes in the various subjects.

**Fees.**—In one payment of 110 guineas, or two payments of 60 guineas each, payable on entrance, and at the commencement of second year respectively, or by six payments distributed over six sessions of 25 guineas and 20 guineas alternately. Fees for shorter periods or for single courses may be learned on application to the Dean. Fees for dental students, payable in one sum on entrance, 50 guineas, or in two instalments of £27 10s.

**LONDON SCHOOL OF MEDICINE FOR WOMEN (ROYAL FREE HOSPITAL).**—This school, which is situated in Hunter Street, Brunswick Square, opens at the same time, and the periods of study, lectures, &c., are similar to those at the ordinary medical schools. A dissecting-room, physiological, chemical, biological, physical, and pharmaceutical laboratories, and library are provided at the School, and clinical lectures are regularly delivered at the Royal Free Hospital close by, which institution is appropriated to the students at the School as a field of practical study; clerkships, dresserships, being tenable there without fee by women.

**Scholarships, &c.**—Entrance Scholarships of £30. The St. Dunstan's Medical Exhibition, value £60 a year for three years, extendible to five years. Bostock Scholarship, £60, for two or four years, given on the result of the Preliminary Scientific Examination of the University of London. The John Byron Scholarship of £20 a year for four years, the Stuart Mill Scholarship of £30 a year for four years, the Fanny Butler Scholarship of £14 10s. a year for four years are offered from time to time. The Mabel Webb Research Scholarship, value £30 for two years, for research work in chemistry, physiology, or pathology. The Helen Prideaux Prize of £50 is offered every other year to graduates of the School. Prizes of £10 each are awarded in the classes of anatomy and physiology. Three Evans Prizes of £3 3s., £2 2s., and £1 1s. respectively are given in the midwifery class, and two Durham Prizes of £5 and £3 are given in the gynaecology class every second year. A prize of £5 is given in alternate years in the midwifery and gynaecology classes. An Evans Prize of £5 5s. is given for operative midwifery. Two Mackay Prizes of £20 each are offered annually. There are other scholarships for ladies willing to qualify themselves as practitioners in India. There is also a small fund from which assistance can occasionally be given to students who specially require pecuniary help.

**Fees.**—The fee for the ordinary curriculum of clinical lectures is £90 if paid in one sum, or £95 if paid in instalments. The fee for clinical teaching is £35, or £40 if paid in instalments.

Special Classes for the Preliminary Examination of the University of London. For the whole course, 20 guineas.

### EXTRA-ACADEMICAL INSTITUTIONS IN LONDON.

**COOK'S MEDICAL SCHOOL.**—This school is prepared to admit to its supplementary work all who may wish to join the same, but in regard to its curriculum work it does not receive more than half-a-dozen students in the course of the year; these have special advantages both as regards anatomy and physiology, at charges but slightly in excess of current rates. By decision of various examining bodies gentlemen rejected at their anatomical and physiological examinations (second conjoint, &c.) can get signed up for the supplementary work they are required to put in before re-examination. The school is also recognised for the special dissections for the Fellowship of the Royal College of Surgeons. The surgical operations are performed on the dead body, and these courses are recognised for army examinations, the Indian Medical Service, &c. The school possesses a good collection of physiological and chemical apparatus, and gentlemen preparing for the higher examinations, the F.R.C.S.Eng., M.B.London, Cambridge, Oxford, &c., receive special instruction in the more difficult subjects by separate classes.

**LONDON SCHOOL OF DENTAL SURGERY.**—This institution is the oldest of the Dental Colleges in the United Kingdom, and its teaching is recognised by the Royal College of Surgeons for the dental diploma. It is centrally situated in Leicester square, is open daily, and under the supervision of a special staff and house surgeon. The mechanical laboratory is the most perfect of its kind, and its usefulness can hardly be over-estimated. The Hospital having been rebuilt during the past year the accommodation is equal to all requirements. Four demonstrators have been appointed to instruct the new students in the elements of operative dental surgery, and at the beginning of the session each demonstrator gives a course of lectures on this subject. There is the Saunders Scholarship and Walker Scholarship (entrance) value £20 each, awarded yearly, and the eight house surgeons are filled by students of the hospital holding the L.D.S. Fee for two years' hospital practice required by the curriculum including lectures, £50. The fee for three years' tuition in mechanical dentistry is 150 guineas.

**NATIONAL DENTAL HOSPITAL.**—This institution is situated in North-West London (Great Portland-street), and the same teaching facilities and hospital practice are obtainable here as at the foregoing institution, special demonstrations being given by members of the staff daily. There are also a mechanical laboratory, students' common room, a metallurgical laboratory, extraction and stopping rooms, students' hall, &c., all lighted by electricity, and warmed and ventilated after the most approved requirements; in fact, this institution may be pronounced a model dental hospital and school. The winter session commences at the same time as at the medical schools on October 1st. The medical tutors hold special classes before each College examination. The prizes include one entrance exhibition, value £15, and the Bymer prize of £5 5s. The fee for two years' hospital practice required by the curriculum, including lectures, is £40.

**LONDON SCHOOL OF TROPICAL MEDICINE.**—This institution is the outcome of a suggestion by the Right Hon. Joseph Chamberlain, H.M. Secretary of State for the Colonies, and is situated at the Royal Victoria Docks, in connection with the Seamen's Hospital, than which no more suitable spot could be found, as ships arrive there in greater numbers than elsewhere from all parts of the Tropics, affording immediate opportunity for the treatment of patients and for the study of tropical diseases. The school buildings are placed within the hospital grounds, and systematic courses of instruction are obtainable from duly authorised teachers throughout the year. Students also have the privilege of attending the medical and surgical practice at the Dreadnought Hospital, Greenwich. Information as to fees, &c., can be obtained of the Dean or the Secretary.

**UNIVERSITY EXAMINATION POSTAL INSTITUTION.**—This is an Institution conducted by Mr. E. S. Weymouth, M.A. (27, Southampton Street, Strand), which

offers special courses of lessons through the post for the M.D. (London or Durham), D.F.H. (Cambridge, London, &c.), and the F.R.C.S. (Eng. or Edin.). The tutors have the M.D. or M.S. degree. Two are gold medallists.

Medical students are admitted to the practice at the following metropolitan hospitals, to which no medical school is attached. Detailed particulars will be supplied on application to the various secretaries.

**WEST LONDON HOSPITAL, Hammermith.**—This contains over 160 beds, and has an extensive out-patient department. Dresserships and clinical clerkships may be obtained. Two house-surgeons and two house physicians are elected every six months. Special departments have recently been opened for diseases of the throat, ear, skin, and deformities. An electrical department has also been added.

**GREAT NORTHERN CENTRAL HOSPITAL, Holloway Road, N.**—This institution has been recently enlarged, and now contains 159 beds. The practice of the hospital is open to practitioners and senior students, and clinical and pathological assistants are appointed in the wards and out-patient departments, as in the larger general hospitals.

**BETHLEM ROYAL HOSPITAL.**—Two Resident House Physicians who have recently obtained their diplomas to practise medicine and surgery, are elected every six months, and are provided with apartments, complete board, attendance, washing, and an honorarium of 25 guineas per quarter. The students of certain specified London medical schools receive clinical instruction in the wards of the hospital, and qualified practitioners may attend for a period of three months on payment of a fee.

**NATIONAL HOSPITAL FOR EPILEPSY AND OTHER DISEASES OF THE NERVOUS SYSTEM, Queen's Square, W.C.**—Contains 200 beds. It has on its staff men of European reputation, and the Institution is recognised by the Conjoint Board where part of the fifth year of study may be devoted to clinical work. Clinical clerks are appointed to the physicians for out-patients, and courses of lectures and clinical demonstrations are given each year.

**HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST, Brompton.**—The largest institution for the treatment of affections of the chest in the United Kingdom, there being 320 beds in the two buildings. There are four house physicians, who reside in the hospital, each for a period of six months. Lectures and demonstrations are given by members of the medical staff on Wednesdays and Fridays at 4 o'clock, save during the vacations. Pupils are admitted to the practice of the hospital. Terms, £3 3s. for three months; six months, £5 5s.; perpetual, £10 10s.

**CITY OF LONDON HOSPITAL FOR DISEASES OF THE CHEST, Victoria Park.**—This is a large and well-equipped hospital at the East End, containing 164 beds. Clinical lectures and demonstrations are given by the members of an exceptionally experienced staff. Fee for three months' attendance on hospital practice, 2 guineas; six months, 3 guineas.

**CENTRAL LONDON THROAT, NOSE, AND EAR HOSPITAL, Gray's Inn Road,** contains seventeen beds, with an extensive out-patient department recently enlarged. Clinical demonstrations and instruction to qualified practitioners and senior students daily during the hours of the surgeon's visits. Twelve clinical assistants who must be duly qualified are elected to assist the surgeons. Operation days—in-patients, Tuesdays, 2.15 p.m.; out-patients, Tuesdays and Fridays, 2 p.m. Fees for the three months' attendance, £3 3s.; six months, £5 5s. Full details of this institution will be found on reference to our advertising columns.

**HOSPITAL FOR DISEASES OF THE THROAT AND CHEST, Golden Square, W.,** with branches at Newington, Walworth and Notting Hill, contains 50 beds. Students are admitted to hospital practice on payment of fee of three months' course, £3 3s.; for six months, £5 5s.; perpetual, £7 7s.

**THE HOSPITAL FOR WOMEN, Soho Square.**—The hospital contains 61 beds. In connection with this institution there is now an organised school of gynaecology, open to qualified medical men and to students after their third year. Clinical assistants to the physicians and surgeons in the in-patient and out-patient departments are appointed every three months. Fee for the three months' course, £5 5s.

**THE SAMARITAN FREE HOSPITAL FOR WOMEN AND CHILDREN, Lower Seymour Street, W.,** offers excellent opportunities for clinical study and training in the details of operative gynaecology. The success of the staff in this department have gained for them an European reputation. There are 47 beds.

**HOSPITAL FOR SICK CHILDREN, Great Ormond Street, Queen's Square, and Cromwell House, Highgate.**—Fee for three months' attendance, £3 3s.; perpetual, £5 5s. There are now 200 beds, besides 52 additional at the convalescent branch, and it is probably the largest institution of the kind in the world. The practice of the hospital has been thrown open gratuitously to pupils of the different hospitals and medical schools of London, on conditions to be ascertained from the secretary.

**ROYAL LONDON OPHTHALMIC HOSPITAL (formerly in Moorfields, rebuilt during the present year in the City Road),** is the largest hospital devoted to this specialty in Great Britain, and contains 131 beds. Students and practitioners are admitted to the practice daily at nine o'clock. Operations, 10 o'clock and after. Fee for six months, £3 3s.; perpetual, £5 5s. Further particulars of the secretary.

**ROYAL WESTMINSTER OPHTHALMIC HOSPITAL, King William Street, Charing Cross,** has about 84 beds, and a very large out-patient clinique. The lectures and demonstrations are arranged with special reference to the requirements of practitioners and senior students. Fee, six months, £3 3s.; perpetual, £5 5s.

**ROYAL EYE HOSPITAL, St. George's Circus, Southwark.**—There are 40 beds and 2 cots. Fees £2 2s. for 3 months, £3 3s. for 6 months, and £5 5s. perpetual. Courses are held on ophthalmoscopy, refraction and diseases of the eye; fee £1 1s. for each course, but perpetual students may attend each course once without extra fee. Pathology class, £1 1s. extra to cover cost of materials.

**ST. PETER'S HOSPITAL FOR STONE.**—This is the only special hospital for the treatment of stone and genito-urinary diseases in the United Kingdom. It contains 27 beds and one private ward, and has an excellent record. Students are admitted on the usual terms.

**LONDON TEMPERANCE HOSPITAL.**—The hospital contains 110 beds. The medical and surgical practice is open to students and practitioners. Appointments (vacancies for which are advertised in the medical journals): Surgical and medical registrars, resident medical officer, and one assistant resident medical officer.

**METROPOLITAN HOSPITAL, Kingland.**—This was until recently known as the Metropolitan Free Hospital, is situated in the north-eastern district of the metropolis, and contains 160 beds. It is a general hospital, with various special departments for the treatment of diseases of the eye, throat, ear, &c.

**SKIN HOSPITALS.**—"St. John's Hospital for Diseases of the Skin." Out-patient department, 49, Leicester Square; In-patient Department, 288, Uxbridge Road. This hospital has now a well-equipped in-patient department, with 50 beds. A School of Dermatology in connection with the hospital was opened last April, and conducted by the medical staff of the hospital. During the past year the free course of Chesterfield Lectures given by Dr. Morgan Dockrell has proved a great success, being well attended by the profession. The next course (free) will commence in October next, and the dates and times will be duly announced in our columns.

One of the oldest institutions of the kind is the Western Skin Hospital, which was started as long ago as 1851. In recent years the number of patients has greatly increased. The practice of the hospital is open to students and practitioners. Students of this specialty have also the "London Skin Hospital," in Fitzroy Square, with seven beds and an out-patient depart-

ment of over 1,400. There is also the Stamford Street Skin Hospital, in the southern part of the metropolis, with 10 beds and an out-patient department of 5,600, so that the students' needs in this direction are well catered for.

## PROVINCIAL MEDICAL SCHOOLS.

**BRISTOL UNIVERSITY COLLEGE.—FACULTY OF MEDICINE.**—This is the only medical school in the West of England. The lectures and instruction given in the Faculty of Arts and Science of University College, Bristol, are adapted to the various preliminary examinations, and students can complete in Bristol the entire course of study required for the medical and surgical degrees of the University of London and the Royal College of Surgeons of England, and of the Apothecaries' Society of London, and for the examination of the Army and Navy Boards. It is now arranged that students of the college shall be admitted to the clinical practice of the Bristol Royal Infirmary and the Bristol General Hospital conjointly, and consequently both these institutions are open to all students. The infirmary and the hospital comprise between them a total of 470 beds, and both have very extensive out-patient departments. Special departments for the diseases of women and children, and of the eye, ear, and throat, besides large outdoor maternity departments and dental departments. Students of the college also have the privilege of attending the practice of the Bristol Royal Hospital for Sick Children and Women, containing 104 beds, and that of the Bristol Eye Hospital, with 28 beds. The total number of beds available for clinical instruction is therefore 602. Very exceptional facilities are thus offered to students for obtaining a wide and thorough acquaintance with all branches of medical and surgical work.

**Appointments.**—At the Royal Infirmary, and also at the General Hospital, clinical clerks and dressers reside in the house in weekly rotation. A pathological clerk is appointed every three months. Also obstetric clerks and ophthalmic dressers.

Clinical lectures are given regularly at both institutions.

**Scholarships, Prizes, &c.**—Prizes and certificates of honour are given in University College in all the subjects of the curriculum, open only to perpetual students. There are two entrance scholarships, value £50 and £30 respectively, two Martyrs' memorial scholarships (pathology and morbid anatomy) of £10 each, the Tibbit's memorial prize, value £9, for proficiency in practical surgery, one gold and silver medal awarded by the committee, and various prizes for clinical work in surgery and medicine.

**Fees.**—School fees for attendance on all courses of lectures, except comparative anatomy, 65 guineas, or 55 guineas. Dental composition fee, 55 guineas. Clinical fees—Surgical practice, one year, 12 guineas; perpetual, 20 guineas. Medical practice, 20 guineas; perpetual medical and surgery, 35 guineas; clerk or dresser, 5 guineas; obstetric clerk, 3 guineas.

Prospectus and further information on application to the Dean, Professor E. Markham Skerritt.

**YORKSHIRE COLLEGE SCHOOL OF MEDICINE, LEEDS.**—This school, which was founded seventy years since as the Leeds Medical School, forms the medical department of Yorkshire College, one of the colleges constituting the Victoria University. Students of the Yorkshire College are therefore eligible for the degrees of the Durham and Edinburgh Universities, and for the ordinary diplomas. The building erected on a site contiguous to the infirmary, and opened five years ago, contains one of the finest dissecting rooms in the kingdom, extensive laboratories for physiology and pathology, with the most recent improvements in fittings and apparatus, ample lecture-room accommodation, a large library, and separate museums for pathology and anatomy. Professors and lecturers are attached, and the clinical teaching is given by the physicians and surgeons attached to the infirmary. Ophthalmic demonstrations and demonstrations of skin diseases are given in the infirmary by surgeons in each department, where also are obtainable various clinical clerkships, dresserships, and other

appointments; and an extern maternity charity is attached, at which the necessary attendance at labours can be taken; besides the infirmary there are a large dispensary, a large hospital for infectious diseases, and a hospital for women and children, all of which are open to students of the school.

Students here have also excellent opportunities of acquiring a thorough insight into psychological medicine, as the renowned West Riding Lunatic Asylum is in connection, whereat lectures on mental diseases are delivered during the summer.

*Scholarships, Prizes, &c.*—(1) A Gilchrist scholarship of £50 a year for three years is awarded annually, and second biennially, to the candidate who stands highest at the June Preliminary Examination at the Victoria University, provided he passes in the first division. (2) A university scholarship of £50 is awarded annually on the results of the second examination for the degree of M.B. and B.Ch., held in March. (3) An entrance scholarship of 64 guineas (covering composition fee for a full curriculum of lectures) is offered every September to university students. There are also a Hardwick prize in clinical medicine, a M'Gill prize in clinical surgery, each of the value of £10, and Thorpe prizes of £10 and £5 in forensic medicine and hygiene, and a Scattergood prize in midwifery, besides silver and gold medals and other class prizes. The composition fee for attendance upon all the required courses of school lectures is 64 guineas for university students who have attended the preliminary scientific courses, and the same for non-university students, exclusive of chemistry and biology.

At the General Infirmary, containing 447 beds, the perpetual fee for medical and surgical practice and clinical lectures is £42 in one sum, or two instalments of £22 each. These fees are not included in the composition fees for lectures, and are payable separately.

A scholarship of £42 to cover the cost of medical and surgical practice is also offered annually.

**UNIVERSITY COLLEGE LIVERPOOL (VICTORIA UNIVERSITY) MEDICAL FACULTY.**—New medical buildings are at present in course of erection, comprising departments of anatomy, surgery, anatomical museum, and laboratory and lecture room accommodation for the School of Dental Surgery, materia medica, toxicology, &c. These adjoin the physiological and pathological laboratories, which were recently built and equipped by the generosity of the Rev. S. A. Thompson-Yates, at a cost of over £30,000. The laboratories include theatres for physiology and pathology, laboratories for microscopic, physical and chemical physiology, for morbid anatomy, bacteriology, and chemical pathology, special rooms for research, &c., private rooms, students' common room and lavatories. The chemical rooms have been extended, so as to provide (*inter alia*) more complete accommodation for medical students and those engaged in laboratory work for diploma in public health. The Chair of Hygiene has secured adequate permanent accommodation in Ashton Hall, an institute adjacent to the college, which contains ample class-room and laboratory accommodation for study and research. The museums of anatomy, pathology, and materia medica are furnished with complete provision for the needs of students, and have recently been reorganised and revised. The museum of hygiene, accommodated in Ashton Hall, has been recently established on the lines of the Parkes Museum. It contains meteorological instruments and numerous models and specimens. Under the supervision of the professor of hygiene a course of lectures on sanitary science is given during the winter, suitable for candidates for sanitary inspectors' certificates.

**ROYAL INFIRMARY.**—The Royal Infirmary, which adjoins the school, contains 300 beds, with 40 special beds for the treatment of diseases of women. The Lying-in, Eye and Ear, Women's, Children's, Dental and Skin Hospitals are in the immediate vicinity, and their practice is open to the students of the medical faculty.

*Fees.*—The composition fees are £24 15s. for preliminary scientific classes; £60 for the medical classes required for the Victoria, London, and other University degrees; £70 for all the classes required for the diplomas

of the Conjoint Boards. The medical composition fees are payable in two instalments, at intervals of twelve months. The fee for hospital attendance at the Royal Infirmary is 40 guineas, also payable in two annual instalments.

*Appointments.*—Three house surgeons, three house physicians, and one extern house surgeon to the Thornton Wards are appointed for six months, after (if necessary) competitive examination. Candidates must have a legal qualification. Clinical clerks for each physician, dressers for each surgeon, and clerks to the Thornton Wards for diseases of women are appointed every three months. Post-mortem clerks are appointed for six weeks. All students are required to perform this duty before the schedule for the final examination is signed.

*Fellowships and Scholarships.*—Fellowships, scholarships, and prizes of over £600 are awarded annually. (a) A Holt Fellowship in pathology and surgery, of the value of £100 for one year, is awarded annually by the Medical Faculty to a senior student possessing a medical qualification. The successful candidate is required to devote a year to tutorial work and investigation in the pathological department. (b) A Holt Fellowship in physiology, awarded under similar conditions, of the value of £100 for one year. (c) A Robert Gee Fellowship in anatomy, awarded under similar conditions, also of the value of £100 for one year. (d) An Alexander Fellowship for research in pathology, of the annual value of £100, renewable. (e) A Johnston Colonial Fellowship in pathology and bacteriology (£100 a year, renewable). (f) A John W. Garrett International Fellowship in physiology and pathology (£100 a year, renewable). (g) Two Lyon Jones Scholarships, of the value of £21 each for two years, are awarded annually; a Junior Scholarship, open at the end of the first year of study to Victoria University students, in the subjects of the First M.B. Examinations; and a Senior Scholarship, open to all students in the school at the end of the second or third year of study, on the subjects of anatomy, physiology, and therapeutics. (h) The Derby Exhibition of £15 for one year is awarded in clinical medicine and surgery in alternate years. Students may compete in their fourth and fifth years; in 1901 the subject will be clinical surgery. (i) The Torr gold medal in anatomy, and the George Holt medal in physiology, the Fletcher prize in physiology (£3 3s. in books), the Kanthack medal in pathology, the Robert Gee book prize, of the value of £5, for children's diseases, and numerous class prizes are awarded annually.

*Entrance Scholarships.*—Four Robert Gee Entrance Scholarships of the value each of £25 for one year are offered annually for competition. The holder is required to take out the science course for the University degree in medicine.

Communications should be addressed to the dean, Professor Paterson, M.D., University College, Liverpool.

**SCHOOL OF DENTAL SURGERY.**—A new mechanical laboratory has recently been erected at the Dental Hospital; it is adequately equipped with all modern appliances, and is under the charge of a skilled mechanic. The fees for dental education are £50 (payable in two instalments) for the Medical School curriculum; £21 payable on entrance, for two years Dental Hospital practice; £10 10s. for general hospital practice (two winters). A limited number of apprentices are taken at the hospital: fee (for three years) £105. Numerous scholarships and prizes are offered; (a) a Fletcher Scholarship of £21 in mechanical dentistry; (b) a Phillips Scholarship of £10 10s. in dental surgery; a Council Prize for dental mechanics (£5 5s. in books); Ash's Essay Prize (£2 2s.), &c.

Prospectuses and further information may be had on application to the Registrar, University College, Liverpool.

**MANCHESTER.—OWENS COLLEGE SCHOOL OF MEDICINE, VICTORIA UNIVERSITY.**—The medical school buildings, which include large laboratories, dissecting-rooms, library and reading rooms, are on the most modern principles, and students wishing to engage in anatomical, physiological, or pathological research will find excellent opportunity for study in the complete and well-furnished



laboratories. The buildings were extended only a few years ago, but owing to the rapid growth of the school further large additions have been made, including lecture theatres and laboratories. Hospital practice is taken out at the Royal Infirmary, which contains 300 beds. The Cheadle Lunatic Asylum, St. Mary's Hospital, the Southern Hospital, and other special hospitals also afford teaching facilities of great importance.

**Appointments.**—The following appointments are made in connection with the Manchester Royal Infirmary: Surgical registrar, at £80 per annum; a pathological registrar, at £100 per annum; a medical registrar, at £70 per annum; two assistant medical officers, each at £80 per annum; a resident medical officer at the Convalescent Hospital, Cheadle, one year £150 per annum; resident medical officer, one year, £150; resident surgical officer, one year, £150 per annum; two chloroformists, annually, at £50; two house surgeons and one house physician are appointed every three months for a term of six months; a resident assistant at the Convalescent Hospital, Cheadle, appointed every six months.

**Scholarships.**—Dalton Entrance Scholarships, £40 per annum, for two years; Cartwright Entrance Scholarship, £35 per annum, for three years; Hulme Entrance Scholarship, £35 per annum, for three years; Rogers Entrance Scholarship, £40 per annum for two years; Eaton Entrance Scholarship, £40 per annum for two years; James Gaskill Entrance Scholarship, £40 per annum for two years; Kay Shuttleworth (Sir Jas. Philips) Scholarship, £30 per annum for three years; Theodores Modern Languages Exhibition, £15; Honorary Research Fellowships; Manchester Grammar School Scholarship, £18 per annum for three years; Turner Scholarship of £20 to students who have completed four years of study in the College; Platt Physiological Scholarship, value £50, tenable for two years, open to students between the ages of 18 and 25; two Platt exhibitions, £15 each, for first and second year's students in physiology; Sidney Benschaw Physiological Exhibition, £15; Dumville Surgical Prize, £15, at the end of the winter session; two Dauntsey Medical Entrance Scholarships, value £35, tenable for one year; John Henry Agnew Scholarship in Diseases of Children, value about £30 awarded annually; Gilbert Scholarships of £50 per annum tenable for three years in any of the Colleges of the Victoria University, awarded annually to the candidate gaining the highest number of marks in the first division of the Preliminary Examination of the Victoria University; the Bradley Memorial Scholarship, £20, in Clinical Surgery is offered annually in the summer session to candidates who must be fourth year students; one Medical and one Surgical Clinical Prize are also offered annually.

**Fees.**—Composition fee, £70, in two sums of £35 each, Hospital practice: composition fee, £40, or two instalments of £25 each.

**Dental Fees.**—Composition fee, £50, payable in two sums of £25 each. Hospital practice, £21.

**SHEFFIELD UNIVERSITY COLLEGE MEDICAL DEPARTMENT.**—The medical department contains a medical library, good class-rooms, an excellent anatomical department, and every provision for medical education under the most modern principles. The physiological department has been entirely reconstructed and equipped in memory of the late president of the school. Mr. Wm. F. Favell, through the generosity of anonymous donors. The department consists of a lecture and demonstration theatre, students' laboratory, preparing room and galvanometer room, all of which are equipped with the most modern apparatus. New premises have been acquired near the College for the pathological museum and laboratory, and also for a bacteriological laboratory, which has been completely equipped through the generosity of "A Sheffield Citizen." The course of lectures and instruction is adapted to meet the requirements of the various examining bodies. Full courses of instruction required for the D.P.H. are given. The new dental department has been recognised by the examining bodies. Students at this college obtain medical and surgical practice at the Royal Infirmary, a well-appointed institution, containing 240 beds, and also at the

Sheffield Royal Hospital, containing 125 beds. The fees for attendance, £6 6s. each for medical and surgical practice during the winter session, and for three months £3 3s. each. Perpetual fee for medical and surgical hospital practice in a single payment of £45, or in two payments, viz., £26 on entrance, and £22 within twelve months afterwards. Students are also admitted to the practice of the Jessop Hospital for Diseases of Women, to the City Fever Hospitals, and to the South Yorkshire Lunatic Asylum at Wadale. The winter session will commence on October 1st, when the introductory address will be delivered by Sir Thomas Barlow, Bart.

**Scholarships, &c.**—An entrance scholarship of the value of £110 is annually awarded to the best candidate (if of sufficient merit) in mathematics, elementary physics, inorganic chemistry, Latin, English.

Composition fee, 60 guineas, or in two instalments of 35 guineas and 30 guineas for lectures and practical classes required by the Examining Board in England.

The Kaye scholarship, for second year's students, natives of Sheffield, is awarded annually, under certain regulations. Prizes for clinical medicine and clinical surgery of 10 guineas; Simon prize in pathology, £10; prizes in books and certificates awarded annually.

**UNIVERSITY OF DURHAM COLLEGE OF MEDICINE, Newcastle-upon-Tyne.**—A very commodious and ornate new building has been erected here at a cost of about £31,000. The electric light is installed throughout the whole of the working part of the college. The Royal Infirmary, at which clinical instruction is obtained, contains 280 beds. Pathological demonstrations are given as opportunity offers. Practical midwifery can be studied at the Newcastle Lying-in Hospital. Opportunities for practical study are also afforded by the Dispensary, City Infectious Diseases Hospital, Eye Infirmary, Children's Hospital and Northumberland County Lunatic Asylum. Lectures are given on psychological medicine and public health.

**Appointments.**—Assistant demonstrators of anatomy receiving each an honorarium; prosectors for the professor of anatomy, assistant demonstrators of physiology and pathology, assistants to the dental surgeon, clinical clerks, and dressers are appointed at regular intervals. One year's attendance at the College is required on the part of candidates for the degrees in medicine of the University of Durham.

**Scholarships, &c.**—University scholarships, value £100, for proficiency in arts, awarded annually at the beginning of winter session to full students in their first year only. The Dickinson memorial scholarship (value, the interest of £400 with a gold medal) for medicine, surgery, midwifery, and pathology, open to full students who have passed the primary examination of a licensing body. The Tulloch scholarship, interest of £400 annually, for anatomy, physiology, and chemistry. The Charlton memorial scholarship, interest of £700 annually, open to full students entered for the class of medicine at end of the fourth or fifth winter. The Gibb scholarship, interest of £500 annually, for pathology, at end of summer session. Goyder memorial scholarship in clinical medicine and clinical surgery, proceeds of £325 annually. The Luke Armstrong memorial scholarship, interest on £680. The Stephen Scott scholarship in surgery, interest on £1,000. The Heath scholarship in surgery (the next award will be in 1902); the interest on £4,000 is awarded every second year. The Gibson prize in midwifery and diseases of women and children; the interest on £225 is awarded yearly. At the end of each session a prize of books is awarded in each of the regular classes.

**Fees.**—(a) A composition ticket for lectures at the college may be obtained—1. By payment of 70 guineas on entrance. 2. By payment of 45 guineas at the commencement of the first sessional year and 35 guineas at the commencement of the second sessional year. 3. By three annual instalments of 35, 30, and 20 guineas, respectively at the commencement of the sessional year. (b) Fees for attendance on hospital practice: For three months' medical and hospital practice, 5 guineas; for six months, 8 guineas; for one year, 12 guineas; perpetual, 25 guineas; or by three instalments at the commencement of the sessional year, viz., first year 12 guineas; second year, 10 guineas; third year, 6 guineas; or by

two instalments, viz., first year, 14 guineas; second year, 12 guineas.

**UNIVERSITY COLLEGE, CARDIFF, SCHOOL OF MEDICINE.**—This college which is one of the colleges of the University of Wales, has since its foundation, in 1883, prepared students for the Preliminary Scientific examination of the University of London, and for the corresponding examinations of other licensing bodies. In 1893, Chairs of Anatomy and Physiology and a Lectureship in *Materia Medica* and Pharmacy were established, making it possible for students of medicine to spend three out of the five years of prescribed study at Cardiff. Arrangements with the managing committee of the Cardiff Infirmary, give students of the College the privilege of attending this large and well-ordered Hospital which is situated within five minutes walk of University College. Many students, especially from Wales and Monmouthshire, avail themselves of the opportunities thus afforded to pursue the earlier part of the medical curriculum near home. All classes are open alike to both men and women students over sixteen years of age. The courses of instruction given at Cardiff are recognised as qualifying for the examinations of the universities, Royal colleges, and other licensing bodies of Great Britain and Ireland. Having spent two or three years in study at Cardiff, and having passed the corresponding examinations, a student may proceed to London or elsewhere and complete his qualifying course for a university degree or for a college diploma.

Students preparing for the first and second examinations of the Conjoint Board for England or for the corresponding examinations of the Conjoint Board for Scotland, or for those of the Society of Apothecaries may compound for their classes by paying a single composition fee of £40, or by paying £18 10s. and £24 10s. at the beginning of their first and second years respectively.

Those preparing for the preliminary scientific and intermediate examination in medicine of the University of London may compound for their three years instruction at Cardiff by paying a single composition fee of £57 10s., or by paying £13 13s., £28 and £21 at the beginning of their first, second, and third years respectively.

In 1899 a department of Public Health was established, and lecturers in bacteriology and in public health and hygiene were appointed. Medical men preparing for a diploma in Public Health and Hygiene can attend complete courses of lectures and laboratory instruction in this department. These courses are recognised by the University of Cambridge, by the Royal Colleges of Physicians and Surgeons, and by Victoria University.

**Scholarships, &c.**—The attention of students about to matriculate is drawn to the numerous entrance scholarships for exhibitions which are offered at the college for competition in September, most of which may be held by medical students. Full particulars of the examination for these may be obtained from the Registrar.

**LIVERPOOL ROYAL SOUTHERN HOSPITAL.**—The clinical school of this hospital is situated within convenient distance of the school of medicine, and affords every facility for clinical and pathological study. The hospital contains 200 beds, and in addition to the general medical and surgical cases attention is devoted to the diseases of women and children. There is a special ward for medical diseases in connection with the University College laboratories.

The medical and surgical staff visit the wards daily, and the ward instruction is supplemented by weekly clinical lectures. Additions have been made to the teaching staff so that students may now obtain instruction in diseases of the eye, ear and throat. Demonstrations in the use of the X-ray apparatus are given at intervals. There is an excellent pathological department, with laboratory attached, where demonstrations are arranged for and regular instruction is given in practical pathology. The practice of St. George's Hospital for diseases of the skin is free to students, and thus ample opportunity is afforded for acquiring a knowledge of dermatology. In addition to the clinical

clerkships which are allotted to the students the resident posts of ambulance officers are given to the students whom the board may think most suited to hold them every three months. The Alexander Fellowship in Pathology of £100 a year is open to students of this school, three prizes of £5 each are also awarded to the gentlemen who present the best taken series of medical and surgical cases. Fees: perpetual, £26 5s.; one year, £10 10s.; six months, £7 7s.; three months, £4 4s.

There are rooms for a limited number of resident students; terms (exclusive of fee for hospital practice), £15 15s. per quarter. The practice of the hospital is recognised by all examining bodies.

**THE LIVERPOOL SCHOOL OF TROPICAL MEDICINE.**—The Liverpool School of Tropical Medicine has had another busy year, the chief item of interest being the despatch of further expeditions for the purposes of medical research. In March, 1900, Dr. Annett, Dr. Dutton, and Dr. Elliott were despatched to Nigeria (northern and southern), where they spent a considerable time in research work, and have published an important report on the subject. In June the Yellow Fever Expedition, consisting of Dr. Durham and Dr. Walter Myers, were despatched to Para in Brazil, and has not yet returned. One member of the expedition, Dr. Walter Myers, unfortunately lost his life in the performance of his duties, from a fatal attack of yellow fever, contracted whilst conducting an autopsy. The latest expedition of the school is that recently despatched under Major Ross, F.R.S., and Dr. Logan Taylor to Sierra Leone to conduct most important experiments there with a view to exterminating mosquitoes, if possible. In memory of Dr. Walter Myers, the school have founded a Walter Myers' Chair of Tropical Medicine and a Walter Myers' Fellowship of Tropical Medicine, to which Major Ross, F.R.S., and Dr. J. E. Dutton have respectively been appointed. Drs. Fielding Ould, Grunbaum, and Balfour Stewart have been appointed assistant lecturers to the school. No difficulty has been experienced in raising all the money required for the expenses of the school, although these are extremely heavy.

**BRISTOL ROYAL INFIRMARY.**—This is one of the largest provincial hospitals in Great Britain, and contains 270 beds. It is provided with all the necessary appliances for a complete clinical education. The resident appointments are five in number, the two juniors of which are each tenable for six months, and are intended for qualified students of the infirmary, who have previously acted as medical and surgical registrars. Several scholarships and prizes are obtainable. Fees for admission to the medical practice, six months, 7 guineas; twelve months, 12 guineas; perpetual, 20 guineas. The same fees are payable for surgical practice. Perpetual fee for medical and surgical practice, 35 guineas. Dental practice, one year, £7 7s.; perpetual, £12 12s.

The following are the principal provincial hospitals having the greatest number of beds, to which students are admitted where clinical instruction can be obtained, but to which there is no medical school attached:—

**BATH ROYAL UNITED HOSPITAL.**—This is a well-appointed hospital in the West of England, with 120 beds, at which students can obtain clinical instruction. The hospital is recognised by the Colleges, and is licensed for dissection. It contains also an excellent museum and library. Fee for six months' attendance, five guineas; twelve months' ten guineas.

**BRADFORD INFIRMARY.**—The hospital contains 210 beds. Non-resident pupils are received—and abundance of clinical material is obtainable. One year's attendance is recognised by the Examining Boards. Fee, perpetual, £10 10s.

**BRIGHTON SUSSEX COUNTY HOSPITAL** contains 178 beds. It is recognised by the College of Surgeons and by the Conjoint Board. Out-pupils are admitted to the clinical teaching and the classes at a fee of £21 for two years.

**NORFOLK AND NORWICH HOSPITAL.**—This hospital is recognised by the Colleges, and contains 220 beds. Fees,

£10 10s. for six months', £15 15s. for twelve months' medical and surgical practice. Pupils, resident and non-resident, are admitted.

LIVERPOOL NORTHERN HOSPITAL, contains 180 beds. Clinical instruction is given by the staff during the summer and winter sessions. Clinical clerkships and dresserships are open to all students without additional fees. Fees for hospital attendance: Perpetual, £26 5s.; one year, £10 10s.; six months, £7 7s.; three months, £4 4s.; practical pharmacy, £2 2s.

NORTHAMPTON GENERAL INFIRMARY.—The number of beds is 163. Out-pupils are received, and have every opportunity of acquiring a practical knowledge of their profession. Instruction is also given in anatomy and materia medica and practical pharmacy. Non-resident pupils are taken at a fee of £10 10s.

THE ROYAL HOSPITAL, Portsmouth.—The hospital is a preparatory school of medicine and surgery, and the attendance of pupils is recognised by the Examining Boards. The number of beds is 150, and during last year there were 1,303 in-patients and 9,191 out-patients.

ROYAL DEVON AND EXETER HOSPITAL, Exeter.—The hospital contains 218 beds (including special children's wards), and has a good library, museum, dissecting room, and post-mortem room. Attendance on the practice of this hospital qualifies for all the Examining Boards. Arrangements can be made by which students can attend midwifery on application to the House Surgeon.

WOLVERHAMPTON GENERAL HOSPITAL.—The hospital contains 230 beds, attendance at this hospital being recognised by all the Examining Boards. Pupils are trained in clinical work by the medical and surgical staff. Fees: Six months, £6 6s.; twelve months, £12 12s.; perpetual, £21.

#### THE ENGLISH UNIVERSITIES.

The English Universities are six in number, viz., Oxford, Cambridge, London, the Victoria, Durham, and the recently created University of Birmingham. The choice of a university is usually determined by social, geographical, and financial considerations. Evidently students whose parents are able and willing to incur the necessary expense would do well to select one or other of the ancient universities for the possession of their degrees, which invest their holders with a status not accorded by the public to the degrees of equally efficient but more modern educational institutions. To those less favoured by fortune, but blessed with energy and a fair share of intelligence, the London University offers free scope, and its degrees are recognised as the outward and visible proof of high professional attainments untrammelled by the traditions which hamper the older bodies. The Victoria University comprises Owens College, Manchester, University College, Liverpool, and the Yorkshire College at Leeds. It thus covers a wide area and attracts considerable numbers of students whose aim is essentially the possession of a degree in medicine. Durham University has "gone ahead" of late years, and has done much to facilitate graduation by the abolition of irritating and futile restrictions without sacrificing the ideals of university training.

#### OXFORD.

There are two degrees in medicine, M.B. and M.D., and two degrees in surgery, B.Ch. and M.Ch. The M.B. and B.Ch. degrees are granted to those members of the University who have passed the second examination. Graduates in Arts, B.A., are alone eligible for these two degrees. In order to obtain the degrees of M.B. and B.Ch., the following examinations must be passed:—1. Preliminary subjects: Mechanics and physics, chemistry, animal morphology and botany. 2. Professional (a) First Examination (held twice a year): Subjects: Organic chemistry, unless the candidate has obtained a first or second class in chemistry in the

Natural Science School; Human physiology, unless he has obtained a first or second class in animal physiology in the Natural Science School; Human anatomy and Materia medica with Pharmacy. (b) Second Examination: Subjects: Medicine, Surgery, Midwifery, Pathology, Forensic medicine with Hygiene. The approximate dates of the examinations are as follows:—Preliminaries—Mechanics, physics, and chemistry, December and June; Animal morphology and botany, December and March; Professional (First and Second M.B.), June and December.

The degree of M.D. is granted to Bachelors of Medicine of the University who have entered on their thirtieth term on their presenting a dissertation approved by the appointed professors and examiners.

The degree of M.Ch. is granted to Bachelors of Surgery of the University who have entered their twenty-seventh term, who are members of the surgical staff of a recognised hospital, or have acted as dresser or house surgeon in such a hospital for six months, and who have passed an examination in surgery, surgical anatomy, and surgical operations. This examination is held annually, in June, at the end of the Second M.B. Examination.

The First Examination for the degrees of M.B. and B.Ch. may be passed as soon as the Preliminary Scientific Examinations have been completed. The subjects of this examination may be presented separately or in any combination or in any order, provided anatomy and physiology be passed together.

The Second Examination may be passed at any time after the completion of the first. The subjects of medicine, surgery, and midwifery must be passed at the same examination, but candidates are allowed to present themselves in pathology at a separate examination.

*Diploma in Public Health.*—An examination is held yearly in Michaelmas Term, open to all registered medical practitioners. No one is admitted as a candidate unless his name has been on the "Medical Register" for twelve months.

*Scholarships, &c.*—Scholarships in some branch of Natural Science (chemistry, physics, biology) of the average value of £80 per annum, tenable for four years and renewable under certain conditions for a fifth year, as well as exhibitions of less annual value, are awarded after competitive examinations every year by some of the Colleges. Notices of vacancy, &c., are published in the "University Gazette." In February there is competed for annually, by those who, having obtained a first-class in any school (moderations or final), or a scholarship or prize open to general competition in the University, have passed all the examinations for the degree of B.A. A Radcliffe Travelling Fellowship is tenable for three years, of the annual value of £200. The examination is partly scientific, partly medical. A Rolleston Memorial prize is awarded once in two years to members of the Universities of Oxford and Cambridge of not more than ten years' standing for an original research in some biological subject including physiology or pathology.

More detailed information may be obtained from the University Calendar and from the Registrar.

#### CAMBRIDGE.

At the University of Cambridge five years of medical study are required for the M.B. and B.C. degrees. The candidate must have resided nine terms (three years) in the university, and have passed the "previous" examination in classics and mathematics. There are three examinations: the first in chemistry, physics, and biology; the second in human anatomy, physiology, and (2) pharmaceutical chemistry; and the third, in the usual practical subjects with hygiene and pathology; each examination is divided into two parts, which can be taken separately. Subsequently to the third examination an Act has to be kept, which consists in reading an original thesis, followed by an oral examination on the subject of the thesis. As the subjects for the examination for the degree in Surgery are included in the third examination for the M.B. degree, candidates are admitted to the degree of Bachelor of Surgery on passing the third examination for Bachelor of Medicine. The M.D. degree may be taken three years after the

**M.B.** An Act has to be kept, with oral examinations, and an essay to be written extempore. There is also the degree of Master of Surgery, for which the candidate, having already passed for B.C., or being M.A., has otherwise qualified in surgery, has to pursue extra study in surgery, and has a special examination or submit original contributions of merit to the science or art of surgery. The yearly expenditure of a student who keeps his term by a residence in a college is from £150. to £200 a year. This, however, may include all payments to the University and the College—all fees as well as clothes, pocket money, travelling expenses &c. Non-collegiate students have only to pay the University fees which are not large. They lodge and board as they like; their expenses, therefore, are entirely in their own hands.

The University degree grants a diploma in public health without the necessity of residence, the examination being in so much of State medicine as is comprised in the functions of officers of health, and subject to the latest requirements of the General Medical Council. These examinations are held in Cambridge the first week in April and October. Candidates, whose names must be on the Medical Register of the United Kingdom, and need not be members of the University, should send in their applications to the Secretary of the State Medicine Syndicate a fortnight in advance. Every candidate who has passed both parts of the examination to the satisfaction of the examiners will receive a testimonial testifying to his competent knowledge of the subjects comprised in the duties of a medical officer of health.

An abstract of all Regulations may be obtained upon sending a stamped directed envelope to the Assistant Registrar, Cambridge. Full information is contained in the University Calendar.

#### UNIVERSITY OF LONDON.

**The Matriculation Examination.**—Candidates for any degree in this University must have passed the matriculation examination. It is held twice in each year—on the second Monday in January and the second Monday in June; and may be held not only at the University of London, but also, under special arrangement, in other parts of the United Kingdom or in the colonies.

**The Preliminary Scientific M.B. Examination.**—Professional studies pursued before the whole of this examination has been passed will not count towards the course required for the M.B. degree. The subjects are (a) chemistry and physics, (b) general biology. The examination takes place twice in each year, once for Pass and Honours, commencing on the third Monday in July, and once for Pass candidates only, commencing on the third Monday in January.

**Intermediate Examination.**—The Intermediate Examination in Medicine takes place twice in each year—once for Pass and Honours, commencing on the second Monday in July, and once for Pass candidates only, commencing on the third Monday in January. The subjects of the examination are anatomy, physiology and histology, organic chemistry, materia medica, and pharmaceutical chemistry. No candidate shall be admitted to this examination unless he is nineteen years of age and has passed the Preliminary Scientific Examination at least two years previously. Fee for this examination, £5.

**M.B. Examination.**—This examination is held for Pass and Honours in October, and for Pass only in May. The candidate must have passed the Intermediate Examination at least twenty-one months earlier, must have attended lectures and hospital practice in a recognised medical school for two years, including at least two months' attendance on lunacy and infectious diseases, one of which must be subsequent to the Intermediate Examination, must have conducted at least twenty labours, and have acquired proficiency in vaccination.

**Bachelor of Surgery.**—The examination for the degree of Bachelor of Surgery takes place once in each year, in December. Candidates must produce certificates to the following effect:—1. Of having passed the examination for the degree of Bachelor of Medicine in this University. 2. Of having attended a course of instruction in

operative surgery, and of having operated on the dead subject. The subjects of the examination are surgery (including operations on the dead body), pathology, and surgical anatomy. Fee, £5

**Master in Surgery.**—The examination for the degree of Master in Surgery takes place once in each year, in December. Candidates must be bachelors of surgery of at least two years' standing; one year is, however, remitted in the case of candidates who passed the B.S. examination in the first division. The examination comprises mental physiology, surgery, and surgical anatomy.

**Degree of Doctor of M.D.—Doctor of Medicine.**—The degree of Doctor of Medicine is granted after examination to bachelors of medicine of at least two years' standing. The examination comprises medical physiology and medicine, and is conducted by written papers, clinical examination, and *viva voce*. A candidate who presents a thesis approved by the examiners is excused the written examination.

**Doctor of Medicine in State Medicine.**—This degree is granted to bachelors of medicine after examination on producing evidence of having been engaged in the study of State Medicine for at least two years. The examination is the same as for the ordinary M.D., with the exception that State Medicine takes the place of medicine.

**Prizes.**—1. The Sherbrooke Prize is awarded triennially for the best essay, embodying original research in some branch of science.

2. The Granville Prize is awarded in each of the two years intervening between the several awards of the Sherbrooke Prize.

Exhibitions or scholarships are awarded to the first six candidates in honours at the matriculation examination, and, if thought proper, to the first candidate in honours at the other examinations.

#### UNIVERSITY OF DURHAM.

One diploma and six degrees in Medicine and Hygiene are conferred, viz., the degrees of Bachelor in Medicine, Bachelor in Surgery, Master in Surgery, Doctor in Medicine, Bachelor in Hygiene, and Doctor in Hygiene, and Diploma in Public Health. These degrees are open to both men and women.

For the degree of Bachelor in Medicine (M.B.) there are four professional examinations. The subjects for the first are: Elementary anatomy and elementary biology, chemistry, and physics. For the second: Anatomy, physiology, materia medica, therapeutics, and pharmacology. For the third: Pathology, medical jurisprudence, public health, and elementary bacteriology; and for the fourth: Medicine, clinical medicine, and psychological medicine, surgery, and clinical surgery, midwifery, and diseases of women and children.

It is required that one of the five years of professional education shall be spent in attendance at the University College of Medicine and the Royal Infirmary, Newcastle-upon-Tyne.

Candidates who have passed the First and Second Examinations of the University will be exempt from the First and Second Examination of the Conjoint Board.

For the degree of Bachelor in Surgery (B.S.) every candidate must have passed the examination for the degree of Bachelor of Medicine of the University of Durham, and must have attended one course of lectures on operative surgery, and one course on regional anatomy. Candidates will be required to perform operations on the dead body, and to give proof of practical knowledge of the use of surgical instruments and appliances.

For the degree of Master in Surgery (M.S.) candidates must not be less than twenty-four years of age, and must satisfy the University as to their knowledge of Greek. In case they shall not have passed in this subject at the Preliminary Examination in Arts for the M.B. degree, they must present themselves at Durham for examination in it at one of the ordinary examinations held for this purpose before they can proceed to the higher degree of M.S. They must also have obtained the degree of Bachelor in Surgery of the University of

Durham, and must have been engaged for at least two years, subsequently to the date of acquirement of the degree of bachelor in surgery, in attendance on the practice of a recognised hospital, or in the naval or military service, or in medical or surgical practice.

For the degree of Doctor in Medicine (M.D.) candidates must be of not less than twenty-four years of age, and must satisfy the University as to their knowledge of Greek. In case they shall not have passed in this subject at the Preliminary Examination in Arts for the M.B. degree, they must present themselves at Durham for examination in it at one of the ordinary examinations held for this purpose before they proceed to the higher degree of M.D. They must also have obtained the degree of Bachelor in Medicine of the University of Durham, and must have been engaged for at least two years, subsequently to the date of acquirement of the degree of Bachelor of Medicine, in attendance on the practice of a recognised hospital or in the military or naval services, or in medical and surgical practice.

Each candidate must prepare an essay, which must be type written, based on original research or observation, on some medical subject selected by himself, and approved by the Professor of Medicine, and must pass an examination thereon, and must be prepared to answer questions on the other subjects of his curriculum so far as they are related to the subjects of the essay.

For regulations for degrees in Hygiene and for the diploma in Public Health see Calendar 1901-2.

Candidates for any of the above degrees must give at least twenty-eight days' notice to the Secretary of the College of Medicine, Newcastle-on-Tyne.

Residence can be had in a separate hostel for female students at moderate inclusive fees for board, &c., particulars of which and any other college information will be given on application to Prof Howden, Secretary, University of Durham College of Medicine, Newcastle-on-Tyne.

#### VICTORIA UNIVERSITY.

Colleges of the University: Owens College, Manchester; University College, Liverpool; and Yorkshire College, Leeds. Candidates for degrees in medicine and surgery must attend, during at least two years, classes in one of the colleges of the University.

The degrees in the Faculty of Medicine are Bachelor of Medicine (M.B.), Bachelor of Surgery (Ch.B.), Doctor of Medicine (M.D.), and Master of Surgery (Ch.M.). All candidates for degrees in medicine and surgery are required to pass the Preliminary Examination, or to have passed such other examination as may from time to time be recognised for this purpose by the University.

The subjects of the Preliminary Examination are—1, Latin; 2, Elementary Mathematics; 3, Elementary Mechanics; 4, English; 5, one of the following:—(a) French; (b) German; (c) Greek; (d) Italian (e) Spanish; (f) any other modern language, permission to present which has been obtained from the Board of Studies. Notice of intention to present either Italian or Spanish must be given before March 1st in each year.

Before admission to the degrees of Bachelor of Medicine and Surgery candidates are required to send in the usual certificates of age and study as at the other Universities.

All candidates for these degrees must pass three examinations, namely—the First examination; the Second examination; and the Final examination.

**First Examination.**—The subjects of the examination are, 1, Chemistry; 2, Elementary Biology; 3, Physics.

Candidates must have attended, during at least one year, courses of both lectures and laboratory work in each of the above-named subjects.

**Second.**—1, Anatomy; 2, Physiology (including physiological chemistry and histology); materia medica, and pharmacy.

Candidates must have passed the First Examination, and have attended courses of instruction in anatomy (systematic and practical) during two winter sessions and one summer session, in physiology for two winter sessions, in materia medica and pharmacy for one summer

session. Candidates may present themselves separately in (a) anatomy and physiology, (b) materia medica and pharmacy.

**Final.**—The examination is divided into two parts, which may be passed separately or on the same occasion, but the first part cannot be taken before the end of the third year, and the second part cannot be taken less than two years after passing Second M.B. or before the fifth year of medical study in accordance with the University regulations. The subjects of examination are as follows: 1, Pharmacology and therapeutics; 2, General pathology and morbid anatomy; 3, Forensic medicine and toxicology and public health; 4, Obstetrics and diseases of women; 5, Surgery, systematic, clinical, and practical; 6, Medicine, systematic and clinical, including mental diseases and diseases of children. Candidates may select as a first part of the examination two or three of the subjects 1, 2, and 3.

The certificates required from candidates at the final examination are practically the same as for the corresponding examination at the London University, and only those who have previously passed the second examination are admitted to it. The regulations relating to the M.D. and Ch.M. degrees can be obtained on application to the Registrar.

**Fees.**—Preliminary examination, £2; for any subsequent examination, £1; First examination, £5; for any subsequent examination, £2. The fees for the second examination, for the final examination, and for the examination for the degree of Ch.M. are the same as for the first examination. A fee of £10 is payable on the conferring of the degree of M.D., a fee of £4 on the conferring of the degree of Ch.M.

The Preliminary examination is held in June and about the end of September. The first M.B. and Ch.B. is held in June; also about the end of September. The second and final examinations are held in March and July, the examination for Ch.M. in July only.

#### UNIVERSITY OF BIRMINGHAM.

The University of Birmingham grants degrees of M.B., Ch.B., M.D., Ch.M., and also a B.Sc. in the subject of public health. In order to obtain any of these degrees it is necessary that a student shall have passed at least the first four years of his curriculum in attendance upon the classes of the university.

**Degrees of Bachelor of Medicine and Bachelor of Surgery.**—The student must have passed either the matriculation examination of the university or one of the following examinations, which will be accepted in lieu thereof for the present:—(a) The previous examination of the University of Cambridge. (b) Responsons of the University of Oxford. (c) The matriculation examination of any other university in the United Kingdom. (d) The leaving certificate (higher) of the Oxford and Cambridge Boards. (e) The Oxford or Cambridge junior local examinations (first or second class honours). (f) The Oxford or Cambridge senior local examination (honours). (g) The College of Preceptors examination for first class certificate.

Matriculation examinations are held in June and September each year.

**Degrees of Doctor of Medicine and Master of Surgery.**—Candidates for either of these degrees will be required either—(a) To present a thesis embodying original observations in some subject embraced in the medical curriculum and approved by a Board of Medical Examiners; or (b) to pass a general examination (written and practical) in medicine or surgery, according to the degree desired. The University also grants degrees in public health and in dentistry, for both of which amply provision has been made.

**Dental Department.**—The University grants the Degrees of Bachelor and Master of Dental Surgery (B.D.S. and M.D.S.).

**THE GENERAL AND QUEEN'S HOSPITALS.**—The practices of these hospitals are amalgamated for the purpose of clinical instruction under the direction of the Birmingham Clinical Board, by whom all schedules will be signed and all examinations conducted. The hospitals have a total of upwards of 400 beds. 6,000 in-patients

and 80,000 out-patients are treated annually, and many valuable posts are open to students at both.

Further information can be obtained from Professor Windle, Dean, Medical Faculty.

### THE ENGLISH COLLEGES.

The medical corporations in England are the Royal College of Physicians of London, the Royal College of Surgeons of England, and the Society of Apothecaries of London. The two Royal Colleges now co-operate to hold a series of examinations, on passing which the candidate receives the diploma of Licentiate of the Royal College of Physicians (L.R.C.P.), and Member of the Royal College of Surgeons (M.R.C.S.). The Society of Apothecaries grants a complete diploma in medicine, surgery, and midwifery.

CONJOINED EXAMINING BOARD IN ENGLAND (ROYAL COLLEGE OF PHYSICIANS OF LONDON AND THE ROYAL COLLEGE OF SURGEONS OF ENGLAND).

Any candidate who desires to obtain both the above licences is required to complete five years of professional study at recognised medical schools and hospitals, and to comply with the following regulations and to pass the examinations hereinafter set forth.

*Professional Examinations.*—There are three examinations, each being partly written, partly oral, and partly practical. These examinations will be held in the months of January, April, July, and October, unless otherwise appointed. Every candidate intending to present himself for examination is required to give notice in writing to the Secretary of the Examining Board, Examination Hall, Victoria Embankment, W.C., fourteen clear days before the day on which the examination commences, transmitting at the same time the required certificates.

The subjects of the first professional examination are—Chemistry and physics, practical pharmacy, and elementary biology. A candidate may take this examination in three parts at different times. A candidate will be admitted to examination in chemistry and physics and elementary biology before registration as a medical student by the General Medical Council, and he may take pharmacy at any time during the curriculum. Rejection entails a delay of not less than three months from the date of rejection, and the candidates will be re-examined in the subject or subjects in which he has been rejected. If referred in chemistry or biology, he must produce evidence of further instruction at a recognised institution. Any candidate who shall produce satisfactory evidence of having passed an examination for a degree in medicine on any of the subjects of this examination conducted at a university in the United Kingdom, India, or in a British colony, will be exempt from examination in those subjects in which he has passed.

The fees for admission to the first examination are as follows:—For the whole examination, £10 10s.; for re-examination after rejection in Part I., £3 3s.; and for re-examination in each of the other parts, £2 2s.

The subjects of the second examination are anatomy and physiology. Candidates will be required to pass in both subjects at one and the same time. Candidates will be admissible to the second examination at the expiration of two winter sessions and one summer session (or fifteen months during the ordinary sessions) from the date of registration as medical students, and after the lapse of not less than nine months from the date of passing Parts I. and III. of the first examination.

A candidate referred at the second examination will be required, before being admitted to re-examination, to produce a certificate that he had pursued, to the satisfaction of his teachers, in a recognised place of study, his anatomical and physiological studies during a period of not less than three months subsequently to the date of his reference.

The fees for admission to the second examinations are: £10 10s. for the whole examination, and £6 6s. for re-examination after rejection.

The subjects of the third and final examinations are:—Part I. Medicine, including medical anatomy, pathology, practical pharmacy, therapeutics, forensic medicine, and

public health. Candidates who have passed in practical pharmacy at the first examination will not be re-examined in that subject at the third examination. Part II. Surgery, including pathology, surgical anatomy, and the use of surgical appliances. Part III. Midwifery and diseases peculiar to women. Candidates may take this examination in three parts at different times, or they may present themselves for the whole examination at one time.

Fees for admission to the third or final examination are as follows:—For the whole examination, £15 15s. Part I.—For re-examination in medicine, including medical anatomy, pathology, therapeutics, forensic medicine, and public health, £5 5s.; for re-examination in practical pharmacy (if taken at this examination), £2 2s. Part II.—For re-examination in surgery, including pathology, surgical anatomy, and the use of surgical appliances, £5 5s. Part III.—For re-examination in midwifery and diseases peculiar to women, £3 3s.

A candidate referred on the third or final examination will not be admitted to re-examination until after the lapse of a period of not less than three months from the date of rejection, and will be required, before being admitted to re-examination, to produce a certificate, in regard to medicine and surgery, of having attended the medical and surgical practice, or the medical or surgical practice, as the case may be, during the period of his reference; and in regard to midwifery and diseases peculiar to women a certificate of having received, subsequently to the date of his reference, not less than three months' instruction in that subject by a recognised teacher.

### ROYAL COLLEGE OF PHYSICIANS OF LONDON.

*Licentiates.*—Candidates are now subject to the regulations of the Conjoint Examining Board in England.

The following by-laws, amended in conformity with the revised regulations of the Conjoint Examining Board, were re-enacted as follows:—

"Every candidate for the college licence (unless specially exempted) shall be required to produce satisfactory evidence of having passed before the commencement of professional study a preliminary examination on subjects of general education recognised by the college.

"Every candidate shall be required to produce satisfactory evidence of having completed five years of professional study, after passing a recognised preliminary examination before admission to the final examination.

"A candidate shall not be admitted to the second examination until the completion of two winter sessions and one summer session (or 15 months during the ordinary sessions) at a recognised medical school, nor until the expiration of one winter and one summer session after passing Parts I. and III. of the first examination.

"A candidate shall not be admitted to the third (or final) examination till the expiration of five winter and five summer sessions from the date of passing the preliminary examination and of four winter and four summer sessions after passing Parts I. and III. of the first examination, and of two winter and two summer sessions after passing the second examination."

*Members.*—The membership of the college is granted after examination to persons above the age of 25 years who do not engage in trade, do not dispense medicine, and do not practise in partnership. This diploma is only granted to persons already registered, or who have passed the final examination for the licence.

Medical graduates of a recognised university are admitted to a pass examination, but others must have passed the examinations required for the licence of the college. The examination, which is held in January, April, July, and October, is partly written and partly oral. It is directed to medicine, and is conducted by the president and censors. Candidates under 40, unless they have obtained a degree in arts in a British university, are examined in Latin, and either Greek, French, or German. Candidates over 40 are not so examined, and the examination in medicine may in their case be modified under conditions to be ascertained by application to the Registrar. The fee for the membership is £42, but if the candidate is a licentiate £15 15s. is deducted. In either case £6 6s. has to be paid before examination.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

**Membership.**—The candidates are now subject to the regulations of the Conjoint Board.

**Fellowship.**—The Fellowship of the College of Surgeons is granted after examination to persons at least 25 years of age, who have been engaged in professional studies for six years. There are two examinations—the first in anatomy and physiology, which may be passed after the third winter session; the second chiefly directed to surgery, which may be passed after six years of professional study. The second examination may be passed before attaining the age of 25, but the diploma is not granted until that age is reached. Candidates for this part of the examination must have passed the final examination of the Conjoint Board in England, and have been admitted members of the college before they can be admitted thereto, except in the case of graduates in medicine and surgery of recognised universities of not less than four years' standing.

**Fees.**—At First Examination: Members, £5 5s.; non-Members, £10 10s.; £5 5s. returned if rejected. At Second Examination: Members, £10 10s.; if not a Member £21. In the latter case £10 10s. is returned in case of rejection. Further information can be obtained on application to the Secretary of the Royal College of Surgeon, Lincoln's Inn Fields, London, W.C.

SOCIETY OF APOTHECARIES OF LONDON.

**Primary Examination.**—This examination consists of two parts: Part I.—Elementary Biology, Chemistry, Chemical Physics, including the Elementary Mechanics of Solids and Fluids; Heat, Light, and Electricity; Practical Chemistry, Materia Medica, and Pharmacy. A synopsis indicating the range of the subjects may be obtained on application. Part II.—Anatomy and Physiology and Histology. The examination is held in January, April, July, and October.

The Final Examination is held monthly, and is divided into Sections 1 and 2.

Section 1 consists of three parts.

Part I. includes:—Principles and Practice of Surgery, Surgical Pathology, and Surgical Anatomy, Operative Manipulations, Instruments and Appliances.

Part II. includes:—(a) The Principles and Practice of Medicine, including Therapeutics, Pharmacology, Pathology, and Morbid Histology. (b) Forensic Medicine, Hygiene, Theory and Practice of Vaccination; and Mental Diseases.

Candidates passing either (a) or (b) will not be re-examined therein.

Part III. includes: Midwifery, Gynaecology, and Diseases of New-born Children, Obstetric Instruments and Appliances. Candidates may enter for Parts I., II., and III. together or separately.

Section 1 of the Final Examination, or any part thereof, cannot be passed before the expiration of 45 months from the date of registration as a medical student.

Sections 2.—This section consists of two parts.

Part I.—Clinical Surgery.

Part II.—Clinical Medicine and Medical Anatomy.

Section 2 cannot be passed before the expiration of the fifth year.

**Fees.**—The fee for examination is £5 5s., total for the licence, £15 15s.; Re-examination—Primary for each Part, £3 3s.; Final, Sec. I. for each Part, £3 3s.; Final, Sec. II., for each Part, £3 3s.

Further information, with particulars as to the course of study, and of the certificates required, can be obtained from the Secretary to the Court of Examiners, Apothecaries' Hall, E.C.

The licence is a registrable diploma in Medicine, Surgery, and Midwifery, and qualifies the holder to compete for medical appointments in the Army, Navy, and Indian Services, also for Poor-law, Civil, and Colonial appointments.

THE Dental Hospital of London (Leicester Square) has received the sum of £500 from the executors of the late Richard Bowerman West, Esq.

Ireland.

THE IRISH MEDICAL SYSTEM.

THE system of medical teaching in Ireland differs from that in England in important particulars. In London each clinical hospital has its attached medical school, which is fully equipped, and which educates the students of that hospital, and very seldom those of any other. In Dublin, on the contrary, the hospitals and schools are entirely separate (except that Sir Patrick Dun's Hospital is officially connected with Trinity College), and a student of any hospital is free to enter for the whole or any part of his course at any school or hospital he pleases. As might be expected, religion, social rank, and locality of residence have their influence in causing certain classes of students to resort to schools and hospitals suitable to their condition. But scholastic or collegiate regulations impose no restrictions as to the place of study, and as the school and hospital fees are paid in detail in Dublin, and not in a lump sum, as in London, the pupil is absolutely free to do as he pleases.

In London the student bargains with his hospital and schools, in the first instance, for a complete course of instruction, for which he pays, in whole or in part, in advance, and his entire study is conducted within the one institution. In Dublin, on the contrary, the student enters for hospital and for courses of study separately, and takes the courses at any school or hospital he pleases which "gives best value," migrating from one school or hospital to another as he thinks fit.

LODGING AND LIVING OF IRISH MEDICAL STUDENTS.

There is in Dublin no organisation for domestic accommodation of medical students, save for those who are passing through Trinity College, in whose case rooms and "commons" (i.e., dinner) are provided at fixed rates. Those who can afford to pay £6 6s. or £7 7s. per month for their lodging and maintenance may find accommodation in the family of some medical man who receives boarders, in which case they become members of the family for the time being, and subject to its discipline. The majority of Dublin students, however, take a lodging in some economical locality, or they "chum" with some other student for the purpose. It is usual to contract with the lodging-house keeper for board or partial board, but some students cater for themselves.

COST OF MEDICAL EDUCATION IN IRELAND.

The cost of obtaining a medical qualification depends to some extent on the qualification sought. In this connection the following tables may be of use to the prospective student:—

COST OF MEDICAL EDUCATION.

School.	Cost.
School of Physic, Dub. Univ. ...	£119 14s.
Royal College of Surgeons, Dub. Univ., School ...	£124 10s.
Catholic University School ...	£124 19s.
Queen's Colleges... ..	£110 (?)

COST OF DIPLOMATA OR DEGREES.

Qualifying Body.	Cost.
Dublin University ... ..	£27 (to this must be added £83 4s., the cost of obtaining an Arts degree).
Royal University ... ..	£15.
Conjoined Royal Colleges ... ..	£42.
Apothecaries' Hall ... ..	£22 1s.

Thus, the absolute payment will amount to somewhere between £125 and £229 18s., according as the teaching of the Queen's Colleges and the degrees of the Royal University, or the teaching and degrees of Dublin University are taken. For the Conjoint Colleges the entire cost is £166 19s., taking the minimum mode of payment. So that, assuming that extras or voluntary costs are incurred, the total will vary, say from £170 to £200. "Grinding" usually costs £5 5s. for each of the four examinations, but if a student needs private "grinding" in special subjects he must pay extra for them.

This sum, or something like it, may be expended by the student or his parent in paying for lectures, &c., and examination fees as they accrue, and there is no difficulty in obtaining the needful information for his guidance if he likes to pay for his course in this fashion. If, on the other hand, he prefers to pay a lump sum down, he can "apprentice" himself to a teacher who will undertake all monetary responsibility for his education, and who may be able to give him some special advantage as his own pupil at hospital. This so-called "apprenticeship," is very generally a simple contract for the payment of fees, and involves but little of that special teaching which is due by a master to a true apprentice. All the Dublin schools require fees to be paid in advance.

#### DATE OF ENTRY.

The entry of names and commencement of study in Ireland is supposed to date from the 1st of October in each year, but the session really dates from the 1st of November, and the entry of names may be delayed by the dilatory to the 25th of the same month. It should, however, be recollected that no credit is given for studies or attendance until the entry is regularly made. The student must attend three-fourths of the lectures delivered, and if he loses a fortnight at the beginning he must make up for it afterwards by constant attendance.

The student begins work by attending a recognised medical school each morning at ten o'clock, and occupying his day, to five p.m., between lectures and dissections. His vacations are a fortnight at Christmas and a week at Easter, and he finally returns home at the end of June.

#### PRELIMINARY EXAMINATIONS.

The first work of the student is to pass a preliminary examination, without which he cannot get credit for any medical studies pursued. The next is to commence medical study. This he does by entering for lectures at a medical school. From the school registrar he gets a form of certificate, and his third act is to take it or send it to the Branch Medical Council, 35, Dawson Street, Dublin. He is thereupon placed upon the Register of Medical Students (without fee) and his period of study counts from that date. He must register at the earliest possible moment, or he will lose credit for his work.

The only preliminary examination held specially for medical students is now held conjointly by the Royal Colleges of Physicians and Surgeons, but other examinations, e.g., the public entrance at Trinity College, the matriculation of the Royal University, the Intermediate Education passes in the required subjects, and all other examinations recognised by the General Medical Council are accepted as equivalent. The Preliminary of the Dublin Colleges has been considerably increased in severity within the past three years, the examiners being now experts in education, and not necessarily members of the medical profession.

The Preliminary is held in March and September, in the subjects specified by the General Medical Council.

The subjects of examination as prescribed by the General Medical Council are as follows:—1. English language, including a specified author, dictation, grammar, and composition; also parsing and analysis from the book specified. 2. Latin, including grammar, translation from specified authors, and translation of easy passages not taken from such authors. 3. Elements of mathematics, comprising (a) arithmetic; (b) algebra, including simple equations; (c) geometry, Euclid, Books I., II., and III., with easy deductions.

4. One of the following optional subjects:—(a) Greek, (b) French, (c) German. The books specified are:—1. English—Shakespeare, "Merchant of Venice" 2. Latin,—The first and second books of the "Æneid," or the "Jugurthine Wars," or the third book of Livy. 3. Greek—The first book of the "Iliad" or the first book of Xenophon's "Anabasis." 4. French—Fénélon's "Télémaque," Books I., II., III. German—Schiller's "Wilhelm Tell."

#### QUALIFICATION IN IRELAND.

THE Medical Licensing Bodies of Ireland are four in number, and, as a rule, students gravitate into one or other of five classes:—a. Those who enter Trinity College, and take a full graduation in Arts in addition to their professional degrees b. Those who take the licence of the conjoined Royal Colleges of Physicians and Surgeons. c. Those who take the licence of the Apothecaries' Hall. d. Those who take their qualifications at the Royal University of Ireland, where graduation in Arts is not necessary. e. Those who pursue their studies in Ireland, but who migrate to London, Edinburgh, or Glasgow for their licences. Almost all these last-named emigrants come from the Queen's Colleges, and the greater number of them from Belfast, while the Dublin students qualify, as a rule, in Dublin.

We do not attempt to give details as to the requisite courses of instruction for degrees or diplomata, as our epitome must necessarily be insufficient for the information of the student, and we can occupy our available space with information more useful to him. The official information upon which students may depend can be obtained by sending a note to the Registrars of the Licensing Bodies or Schools.

The Irish Licensing Bodies are as follows:—

#### THE UNIVERSITY OF DUBLIN.

THE University of Dublin grants the degrees of M.B., B.Ch., and B.A.O. to students who have obtained their Arts degree, and the higher degrees of M.D. M.Ch. and M.A.O. to those who have held for at least three years the grade of M.B. and B.Ch. It does not grant degrees to any but full graduates in Arts, consequently its degrees hold the highest rank of social and educational qualifications, and are sought for by those who look forward to occupying the best positions in the profession.

The expense of obtaining the degrees of M.B., B.Ch., and B.A.O. is approximately as follows:—Lectures, £64 1s.; Hospitals, £55 13s.; Degree Fees, £27.—£146 14s.

The expense of the B.A., amounting altogether to £83 4s., should be added, making the total cost £229 18s.

*Doctor of Medicine.*—In addition to its ordinary qualifications, the University grants the following higher degree of M.D. To obtain this the candidate must have obtained the degree of M.B., or qualified to have obtained it for three years. He must then read a thesis before the Regius Professor of Medicine. Total fee for this degree, £13.

*Master in Surgery.*—The candidate must be a Bachelor in Surgery of three years' standing, and must then pass an examination in clinical surgery, operative surgery, surgical pathology, surgery, and surgical anatomy (on the dead subject). Fee for the degree of Master in Surgery, £11.

*Master in Obstetric Science.*—The candidate must have passed the M.B. and B.Ch. examinations, and have completed, in addition to the courses for M.B., B.Ch., a course in obstetric medicine and surgery. He is then required to pass an examination in the following subjects:—Practice of midwifery, gynecology, anatomy of female pelvis and elementary embryology, and clinical gynecology. Fee for the degree of M.A.O., £5.

*Diplomate in Medicine, Surgery, and Midwifery.*—The course and examination is the same as for the degree,



except that the lectures and examinations in botany and zoology need not have been taken out or passed, and that the candidate need not have obtained an Arts degree. Fee for the diploma in medicine, surgery, and midwifery, £21.

*Qualification in State Medicine.*—The candidate must be a M.D. of Dublin, Oxford, or Cambridge.

The candidate must have completed, subsequent to registration, six months' practical instruction in a laboratory, and also have studied practically outdoor sanitary work for six months, under an approved Officer of Health.

#### THE ROYAL UNIVERSITY OF IRELAND.

The Royal University of Ireland is purely an examining body. Its degrees are granted on one year's acts, i.e., the matriculation examination of this University (none other will suffice) and a "first University examination" at the termination of the first year. The cost of the M.B. and M.Ch. of the University, with all the necessary curriculum, is about £125. Some of the Arts examinations are conducted, not only in Dublin, but at certain local centres.

The University confers the following medical degrees:—

M.B., M.D., B.Ch., M.Ch., B.A.O., M.A.O., a diploma in sanitary science; a diploma in mental diseases.

All degrees are open to persons of either sex.

The university examinations are held in the spring, beginning about May 1st, and in the autumn, beginning about September 24th.

All candidates for any degree must pass the matriculation examination and the first university examination.

The course for the degree of M.B., B.Ch., B.A.O., extends over five years.

Students will be admitted to the first university examination after one year from matriculation, fee, £1.

The medical course consists of three previous examinations, one at the end of each year, and one degree examination at the end of the fifth year. Fee for each primary, £1; for the degree, £2; for the diploma, £10.

In addition the following degrees are granted:—*Diploma in Sanitary Science.*—Conferred only on graduates in medicine of the university of at least twelve months' standing. Fee, £2. *Subjects.*—Climatology, chemistry, geology, physics, vital statistics, hygiene, sanitary law.

*The M.D. Degree.*—Conferred only on graduates in medicine of the university of three years' standing. Fee, £5. The examination will comprise medical diseases and the theory and practice of medicine, including pathology.

*The M.Ch. Degree.*—Conferred only on graduates in medicine of the university of three years' standing. Fee, £5.

The examination comprises surgery, both theoretical and operative; surgical anatomy; ophthalmology and otology.

*The Mastership of Obstetrics.*—Conferred only on graduates in medicine of the university of three years' standing. Fee, £5.

The examination comprises midwifery and diseases of women and children.

*Prizes, &c.*—First Examination in Medicine. Two first-class exhibitions of £20 each, and two second of £10 each.

Second Examination in Medicine.—Two first-class of £25, and two second-class of £15.

Third Examination in Medicine.—Two first of £30 each, and two second of £20 each.

Medical Degrees Examination.—Two first of £40 each, and two seconds of £25 each. One travelling medical scholarship of £100. One medical studentship of £200 per annum, tenable for two years.

#### ROYAL COLLEGES OF PHYSICIANS AND SURGEONS.

THE examinations held conjointly by the two Colleges are the inlet of most Irish students to the profession, especially of those educated in Dublin. The course, as in other bodies, extends over five years, with examina-

tions at the end of the first, second, third, and final years. These examinations are conducted by examiners chosen by each of the Colleges for the subjects appropriate to them. The five years may be described as—first, preparatory; second, theoretical; third and fourth, application of the theory to practical work; and, final, strictly practical in hospitals, general and special. The regulations are so voluminous that an epitome of them would be unsatisfactory, and we recommend students to apply for the official programme to the Secretary of the Committee of Management, Royal College of Physicians, or to the Registrar of either College.

The total of the examination fees, spread over the four examinations, is £42, while the school and hospital fees, if taken in Dublin, amount to £124 19s., making altogether £166 19s., exclusive of "grinding" or of re-examination fees, which have to be paid in case the candidate fails to pass in all the subjects of his examination at the one time.

The conjoined Colleges also hold Preliminary Examinations in General Education, and confer a diploma in Public Health, of all of which information will be found in the following pages.

#### APOTHECARIES' HALL OF IRELAND (L.A.H.).

This body is authorised to grant a complete qualification in medicine, surgery, and midwifery, recognised and registrable under the Medical Act of 1886, and entitling the holder to occupy medical appointments in all the public services. It also confers the legal right to dispense medicines in Ireland. The examinations are held on the third Monday in January, April, July, and October, and the requirements in respect of studies will be approximately the same as those of the conjoint examinations of the Royal Colleges of Physicians and Surgeons in Ireland. The examination fees payable for the qualification of L.A.H. are as follows:—First professional, £5 5s., second, £5 5s.; third, £5 5s.; final examination, £6 6s.

The fees for re-examination are £1 1s. for each subject, excepting in the subjects of chemistry, pharmacy, surgery, and medicine, the fees for which are £2 2s.

The fee for final alone is £15 15s. Candidates may be admitted to a special examination under special circumstances, at an extra fee of ten guineas.

Candidates already on the Register will receive the diploma of the Hall on passing an examination in medicine, surgery, midwifery, and pharmacy, and paying a fee of ten guineas. If medicine or surgery are required two guineas extra will be charged. The candidate will be exempt from each of the above subjects, which are covered by his previous qualification or qualifications.

In addition to the qualifying diploma awarded by the above bodies there are diploma in special subjects awarded as well. These are the licence in Dentistry and the diploma in Public Health.

#### THE LICENCE IN DENTISTRY.

There is probably no specialty in surgery which gives as great a number of its practitioners a living and the prospect of an income as dentistry. A young man who has got his diploma, and knows something of his business, and is willing to attend to it, seldom fails to get a substantial foothold in Ireland in a few years. The Irish diploma in Dentistry is granted by the Royal College of Surgeons.

*Course of Study for the Licence in Dentistry.*—Candidates are required to pass three examinations, viz.:—Preliminary (in General Education), Primary Dental, and Final Dental.

The Primary Dental examination is in (1) Physics, (2) Chemistry, (3) Anatomy, (4) Physiology and Histology, (5) Surgery—all these subjects with special reference to dentistry. The examination fee is £10 10s. The Final examination is in (1) Dental Surgery—clinical and operative; (2) Dental Mechanics—clinical and practical, including metallurgy. The fee for this examination is, for a Licentiate of the College, £10 10s.; for any other candidate, £26 5s. Each of these examinations must be preceded by complete courses of study in these subjects.

**Exemptions.**—Candidates educated in England or Scotland are admitted to the examination on the production of the certificates that would be necessary for both Primary and Final examinations in their own countries. Furthermore, the College admits to examination, *sine curriculo*, candidates whose names are on the *Dental Register*, and who are unable to furnish the certificates required by the foregoing regulations, on presentation of a special schedule of application, accompanied by any certificate they may have of general or professional education, and by the required fee.

#### THE DIPLOMA IN PUBLIC HEALTH.

This diploma is granted by Dublin University, the Royal University, and the conjoined Royal Colleges. Every candidate must be a registered medical practitioner. The examination is in:—(1) Chemistry (including chemical physics). (2) Engineering and Architecture. (3) Sanitary Law and Vital Statistics. (4) Hygiene. (5) Bacteriology. (6) Meteorology. The General Medical Council recommend that all candidates shall have studied in a special bacteriological laboratory, also for six months as pupil of a working medical officer of health, described, for Ireland, as "the medical officer of health of a county or of one or more sanitary districts having a population of not less than 30,000; or a medical officer of health who is a teacher in Public Health of a recognised medical school.

In Ireland the number of teachers in this category does not exceed, at present, ten, but the recent Sanitary Order of the Local Government Board, which affords facilities for the creation of many additional superintendent medical officers of health, will not only supply the demand, but will stimulate the much-needed sanitary improvement in Ireland.

#### THE IRISH MEDICAL SCHOOLS.

The Irish Medical Schools are as follows:—

**THE SCHOOL OF PHYSIC OF DUBLIN UNIVERSITY.**—This school is formed by an amalgamation of the School of Trinity College and of the College of Physicians. Some of the professors in the schools are *ex officio* medical officers of Sir Patrick Dun's Hospital. The school is freely accessible to all students, and the instruction provided occupies a high rank.

Every student of the school must be matriculated by the senior lecturer, for which a fee of 5s. is payable, but he need not attend any of the Arts course unless he desires to obtain a university licence or degree, in medicine, surgery, and midwifery. No student is permitted to matriculate unless he has passed the entrance examination in Arts in Trinity College, the preliminary examinations of the Royal University, of the College of Surgeons, or some other examination recognised by the General Medical Council.

Two medical scholarships are given annually at the School of Physic, value £20 per annum, tenable for two years, the examinations for which are held each year in June; one scholarship is given in anatomy and institutes of medicine; the other in zoology, chemistry, botany, and experimental physics.

A prize of £100 is awarded by the Board to the successful candidate at a special examination in alternate years in Medicine or in Surgery, provided that the merit be deemed sufficient. The successful candidate is required to spend three months in the study of medicine or surgery as the case may be, in Berlin, Paris, or Vienna. Before he can obtain the first instalment of £50 he must satisfy the Senior Lecturer that he possesses sufficient knowledge of a Continental language to derive full benefit from the prize. The examination is held in June, and is open to students who have passed the Degree Examination in Medicine or in Surgery, as the case may be, within two years of the examination.

In order to obtain the second sum of £50 the prizeman must have furnished to the Regius Professor his formal report on the hospitals attended by him, within two years from the time of obtaining the prize.

Class prizes are given at the end of the session of between £5 and £10 in value.

The John Mallet Purser Medal, founded by Prof. Purser's past pupils, is awarded annually to the student

who, at the ordinary June half M.B. Examination, shall obtain highest marks in Physiology and Histology.

**THE ROYAL COLLEGE OF SURGEONS IN IRELAND. SCHOOLS OF SURGERY.**—By the amalgamation of the Carmichael College and the Ledwich School with the School of the Royal College of Surgeons the combined schools form the largest medical teaching body in Ireland. These schools are attached by Charter to the Royal College of Surgeons. They are carried on within the College building, and are specially subject to the supervision and control of the Council, who are empowered to appoint and remove the Professors, and to regulate the methods of teaching pursued. The buildings have been reconstructed, the capacity of the dissecting room nearly trebled, and special histological, pathological, bacteriological, public health, and pharmaceutical laboratories fitted with the most approved appliances in order that students may have the advantage of the most modern methods of instruction.

The diplomata of the College are open to students of either sex. Separate rooms have been provided, and careful provision made for the instruction and comfort of women students.

**PRIZES.**—The Barker Prize, £21; the Carmichael Scholarship, £15; the Mayne Scholarship, £15. The Gold and Silver Medals in Surgery, and the Stoney Memorial Gold Medal in Anatomy.

Class Prizes of £3 and £1, accompanied by medal if sufficient merit be shown, will also be given in each subject. Prospectus and Student's Guide can be obtained on application to the Registrar, Royal College of Surgeons, Dublin.

**THE CATHOLIC UNIVERSITY SCHOOL** is situated in Cecilia Street, Dame Street. It prepares students for all medical examinations, particularly those of the Irish Colleges of Physicians and Surgeons, and the Royal University of Ireland. The school has recently been rebuilt and refitted, its working space having thereby been nearly doubled, and several new laboratories, including those for the study of bacteriology and public health, have been added. The institution has also been recently chartered, under the Educational Endowment (Ireland) Act, and it is now controlled by a Board of Governors.

The following Exhibitions are awarded annually:—Two first year's, value, £12 10s. each; two second year's, value, £10 each; one third year's Royal Exhibition of £12 10s.; one final of £12 10s.; two large gold medals, besides several other class medals.

A Guide for Medical Students, which gives all the information required by parents, and by students who desire to join the medical profession, may be obtained free on application to the Registrar.

#### THE QUEEN'S COLLEGES—BELFAST, CORK, AND GALWAY.

These three important academic institutions were the special schools of the Queen's University. They have ceased to have any direct relation to a central examining body, but educate students for all colleges and degrees, and are maintained, as hitherto, by a handsome Government grant. The same curriculum as that formerly adopted is continued, and the various exhibitions and scholarships are still available. Each college has the disposal of about £1,500 per annum in scholarships and prizes. The curriculum is generally well adapted for preparation for the Royal University examination. The colleges are well adapted for high-class technical education, having lecture rooms provided with every appliance necessary in the modern training of a medical student. The great want in the colleges of Cork and Galway is a summer session. This necessitates the loss to the student each year of three available working months. The colleges are completely equipped with students' reading rooms and lending libraries and refreshment rooms, and with all adjuncts to collegiate life, such as literary societies and athletic organisations. The students do not, however, reside within the college, but halls of residence and licensed boarding houses are provided for those who do not live with friends. The expense of living in the collegiate

towns is quite moderate. The course of lectures in the winter session must be diligently attended, no student obtaining a certificate who has not put in three-fourths of a course. The winter medical session commences on October 29th and ends about Easter. The scholarships examinations are held in October. An account of the prizes and exhibitions in medicine, the names of the professors, and other information may be found in the advertisements of this issue, and full details may be had on application to—

Belfast, John Purser, LL.D., Registrar.; Cork, Alexander Jaok, M.A.; Galway, Edward Townsend, M.A.

#### DEPARTMENT OF AGRICULTURE AND TECHNICAL INSTRUCTION FOR IRELAND.

ROYAL COLLEGE OF SCIENCE FOR IRELAND.  
SESSION 1901-1902.

This College, situate in St. Stephen's Green, Dublin, supplies a complete course of instruction in science applicable to the industrial arts, especially those which may be cast broadly under the heads of chemical manufactures, engineering, physics, and natural science. A diploma of Associate of the College is granted at the end of the three years' course. Non-Associate students may join for any course required. There are four Royal scholarships of the value of £50 each yearly, with free education, tenable for two years. Two are competed for by the associate students at the end of each session. The chemical, physical, zoological and botanical, geological and mineralogical laboratories and drawing schools are open daily for practical instruction. The session commences on Tuesday, October 1st.

The courses of chemistry, physics, botany, geology and mineralogy, and zoology are recognised by the Royal University of Ireland, and certificates of attendance are granted to medical and other students attending these courses, as also the courses of the chemical, physical, zoological and botanical and geological laboratories.

#### THE DUBLIN HOSPITALS.

The clinical hospitals in Dublin are ten in number, exclusive of three lying-in hospitals. There are also two children's hospitals, an orthopedic hospital, a fever hospital, an ophthalmic hospital with two centres, a dental hospital, and other special institutions. Some of the clinical hospitals, though they have no actual or official connection with any school, are in close affinity with certain teaching bodies; while others, again, are without any special connection with any school. While, however, such affiliation of a school or hospital may exist, it should be remembered that the Dublin schools and hospitals are open to all comers, and the student is competent to attend any hospital or any school he wishes, and to change his place of instruction from year to year as he may see fit.

The Irish Licensing Bodies require attendance on hospitals for twenty-seven months, i.e., three winter sessions of six months and three summers of three months) within the five years of study. The fee at all general hospitals is £8 in winter, and for the summer £6, or £12 for the entire session of nine months if taken together.

#### GENERAL HOSPITALS.

RICHMOND, WHITWORTH, AND HARDWICKE HOSPITALS.—The accommodation of these hospitals is as follows:—Hardwicke Hospital, 120 beds; Whitworth Hospital, 82 beds; Richmond Hospital, 110 beds—total, 312 beds. These hospitals are visited each morning at nine o'clock by the Physicians and Surgeons, and, in addition to the usual bedside instruction, clinical lectures are delivered on the most important cases. Special instruction is also given on various branches of medicine and surgery. The Truss Establishment for the distribution of trusses to the ruptured poor of Ireland is connected with these hospitals. There are very large ophthalmic, aural,

throat, and gynecological dispensaries, and instruction in these important subjects is given. Eight resident clinical clerks are appointed each half-year, and provided with furnished apartments, fuel, &c. The appointments are open not only to advanced students, as formerly, but also to those who are qualified in medicine or surgery. A house surgeon for the Richmond Hospital and a house physician for the Whitworth and Hardwicke Hospitals are elected annually, and receive a salary. The Richmond Lunatic Asylum, containing 1,600 beds, adjoin these hospitals.

MEATH HOSPITAL AND CO. DUBLIN INFIRMARY.—This hospital was founded in 1753, and now contains 160 beds available for clinical teaching. A new building for the isolated treatment of fevers has recently been added. The certificates of this hospital are recognised by all the universities and licensing bodies of the United Kingdom. Medical and surgical resident pupils and clinical clerks and dressers are appointed every six months, and a house surgeon is elected annually. A prospectus giving the complete arrangements for medical and surgical classes for the coming session may be obtained from the secretary of the Medical Board, Dr. Lane Joynt, 84, Harcourt Street, Dublin.

THE ADELAIDE MEDICAL AND SURGICAL HOSPITALS are in Peter Street, and occupy a central position within a few minutes' walk of the College of Surgeons and Trinity College. From October 1st the physicians and surgeons visit the wards and give instruction at the bedside at the advertised hours. There is a large detached fever hospital, and also wards for infants and children. Operations are performed, except in cases of urgency, at 10 a.m. on Tuesday, Thursday, and Saturday. Special hours are devoted to clinical instruction in the diseases peculiar to women, and students are individually instructed in the use of the stethoscope, ophthalmoscope, laryngoscope, and microscope; also special instruction is given on practical pathology and X-ray photography. Three resident pupils are selected half-yearly and a house surgeon annually. Prize examinations, including examinations for the Hudson Scholarship, £30 and a gold medal, and a senior prize of £10 and a silver medal, in addition to surgical and medical prizes, are held at the termination of the session. The large dispensaries afford facilities for the study of eye, ear, throat, and cutaneous diseases, as well as of minor surgery and dentistry. Further particulars from Dr. Houston, 15, Stephen's Green North.

SIR PATRICK DUN'S HOSPITAL is situated on the south-eastern side of the city, and about half a mile from the University School of Physic. It is officered exclusively by the professors and examiners in that school. Formerly all University students were compelled to attend this hospital, which was purely a medical institution, but some years ago the obligation was removed, and the hospital was opened for surgical cases. It is now free to all students.

THE ROYAL CITY OF DUBLIN HOSPITAL.—This hospital is situated in Upper Baggot Street, about ten minutes' walk from the Royal College of Surgeons and Trinity College. It has just been enlarged and improved to a very considerable extent. A special course of instruction is given on ophthalmic and aural disease. There are special wards for the treatment of diseases of the eye, of children, and of women, and practical instruction is given on diseases peculiar to women; there is also a separate building for infectious diseases. Clinical clerks to the physicians and dressers to the surgeons are appointed from the most deserving of the class. A new operation theatre, sterilising room, and anaesthetic room have been constructed in accordance with the most modern surgical requirements. A resident medical officer is elected annually, and resident medical and surgical pupils are appointed from among the past and present students of the hospital. Operations are performed on Tuesdays, Thursdays, and Saturdays, at 10 a.m. Full particulars can be had on application to Mr. G. Jameson Johnston, M.B., F.R.C.S.I., Hon. Sec. Med. Board.

MATEE MISERICORDIE HOSPITAL.—This hospital, containing 385 beds, is open at all hours for the reception

of accidents and urgent cases. Fifty beds are specially reserved for the reception of patients suffering from fever and other contagious diseases. A course of lectures and instruction on fever will be given during the winter and summer sessions. A certificate of attendance upon this course to meet the requirements of the various licensing bodies may be obtained. Opportunities are afforded for the study of the diseases of women in the wards under the care of the obstetric physician, and at the dispensary, held on Tuesdays and Saturdays. Lectures on clinical gynaecology will be delivered on Saturdays at 11 a.m. Ophthalmic surgery will be taught in the special wards and dispensary. A special course of instruction in pathology and bacteriology, as applied to medicine, will be given. Connected with the hospital are extensive dispensaries, which afford valuable opportunities for the study of general, medical, and surgical diseases, accidents, &c. Four house physicians and eight house surgeons will be appointed annually. Ten resident pupils will be elected, each to hold office for six months, from the most attentive of the class. For the current session the elections will take place in November and in May. Dressers and clinical clerks will be appointed, and certificates will be given to students who exhibit proficiency and punctuality in performing their duties. Leonard prizes: one gold and one silver medal will be offered for competition annually in the subject of medicine, and one gold and one silver medal in the subject of surgery. Junior Leonard prizes: two prizes of the value of £3 and two prizes of the value of £2 will be offered for competition in medicine and surgery, respectively. They will be awarded on the aggregate of marks gained by reports of cases, and at a clinical examination to be held at the close of the summer session.

**MERCER'S HOSPITAL.**—This hospital, founded in 1707, is situated in the centre of Dublin, in the immediate vicinity of the Schools of Surgery of the Royal College of Surgeons, the Catholic University School of Medicine and within five minutes' walk of Trinity College. It contains 120 beds for medical and surgical cases, and arrangements have been made with the medical officers of Cork Street Fever Hospital, whereby all students of this hospital are entitled to attend the clinical instruction of that institution, and become eligible for the posts of resident pupil, &c. There is a large out-patient department, and a special department for diseases peculiar to women. There are also special wards for the treatment and study of children's diseases. During the past few years the hospital has undergone extensive alterations in order to bring it up to modern requirements.

**Appointments.**—A house surgeon is appointed annually. Five resident pupils are appointed, each for six months, and clinical clerks and dressers are appointed monthly from among the most deserving members of the class.

The certificates of this hospital are recognised by all the licensing bodies.

For further particulars apply to B. Charles B. Mansell, M.B., F.R.C.S., 32, Lower Baggot Street, Dublin.

**St. VINCENT'S HOSPITAL,** Stephen's Green, Dublin, was established in 1834. The hospital has 160 beds, and in connection with it there is a largely attended dispensary, a convalescent home, and a nurses' institute. In addition to the ordinary clinical instruction, systematic courses of lectures are given in each department of medicine and surgery, and are illustrated by cases in the hospitals. The resident officers consist of a house surgeon, a house physician, and four resident pupils. Three clinical lectures are delivered daily in the wards, illustrated by selected cases, and beginning at 9 a.m. A special feature of this hospital is the division of the students into senior and junior classes, thus providing for their systematic and appropriate instruction from the beginning to the end of the course.

Two gold medals and other valuable prizes and certificates of merit are awarded at the end of each session.

A prospectus can be had from Dr. Tobin, St. Stephen's Green.

**Dr. STEVENS' HOSPITAL,** situated at Kingsbridge, is

one of the oldest and largest of the clinical hospitals in Dublin, and contains over 200 beds. Recently a very fine Nurses' Home has been added to the institution with accommodation for over seventy nurses. And this year a new and thoroughly equipped dispensary and out-patient department has been completed, and opened to patients. The hospital affords exceptional facilities to resident pupils, there being accommodation for four medical and six surgical residents, as well as one to each of the special departments of gynaecology and ophthalmology. Each pupil, during residence, is provided with a separate furnished room, with coals and gas, besides a general sitting-room. The fees for each three months of residence are ten guineas with, and five guineas without, certificate. Licensing bodies recognise six months' residence as equivalent to a year's ordinary attendance at hospital. The manufactories and railway works in the neighbourhood supply this hospital with large numbers of accidents and other cases, while the special ward for venereal diseases affords exceptional opportunities for the study of this important subject.

**JERVIS STREET HOSPITAL, DUBLIN.**—Jervis Street Hospital is the oldest established in Dublin. The new hospital was completed in 1896, since which time it has been opened for the reception of patients. In addition to the large medical and surgical dispensaries, the out-patient department includes special departments for the treatment of diseases of the skin, eye, ear, and throat, and diseases peculiar to women. Two resident surgeons are appointed annually. Clinical clerks and surgeons' dressers are selected from among the most attentive of the advanced students without the payment of any additional fee. Twelve interns are appointed annually, and are provided with apartments, &c., free of expense. Special certificates are given to resident pupils and dressers who have performed their respective duties to the satisfaction of the physicians and surgeons. Gold and silver medals are given after examinations held at the close of the summer session.

#### SPECIAL HOSPITALS.

The special hospitals of Dublin are the Rotunda, Coombe, and National Lying-in Hospitals, Cork Street Fever Hospital, the Royal Victoria Eye and Ear Hospital (amalgamation of St. Mark's Ophthalmic Hospital, and the National Eye and Ear Hospital), the Dental Hospital, the Throat Hospital, the Orthopaedic Hospital, and the Children's Hospitals in Harcourt Street and in Temple Street.

**THE ROTUNDA HOSPITAL.**—This, the largest and best known lying-in hospital of the United Kingdom, is every year becoming more appreciated as a school of midwifery, and of late, more especially, as affording peculiar advantages both to the student and the practitioner for acquiring a thorough knowledge of gynaecology. It contains two distinct departments—viz, the lying-in hospital, into which about 1,600 cases of labour are admitted annually; and the hospital for the treatment of diseases peculiar to women, into which some 500 patients are now admitted during the course of the year. The present master, Dr. Purefoy, was previously well known as Gynaecologist to the Adelaide Hospital. There is a large extern maternity in connection with the hospital, more than 2,000 women being attended during the past year at their own homes, and also a large daily dispensary for the treatment of the diseases peculiar to women. Every facility is afforded for the study of the special departments of medicine to which the hospital is devoted, and both students and midwives are granted a diploma on passing an examination. Two clinical clerks, at a salary of £50 per annum each, are appointed every six months from among the students who have attended the full course of instruction in the hospital. A considerable number of female pupils are also yearly trained as nurse tenders and midwives.

**THE COOMBE LYING-IN HOSPITAL.**—This hospital has accommodation for sixty-five patients, in two divisions, one devoted to midwifery and the other to the diseases of women. The present master is Mr. T. G. Stephens, L.R.C.P., F.R.C.S.I.

**NATIONAL MATERNITY HOSPITAL.**—This institution, under the mastership of Dr. Barry and Dr. H. Horne, is situated in Holles Street.

**SIR PATRICK DUN'S MATERNITY.**—This is a branch of Sir P. Dun's Hospital, and is under the management of the King's Professor of Midwifery in Dublin University. Students desirous of entering for twelve months' instruction in practical midwifery are required to pay a maternity fee of £3 3s. each to the Registrar of the hospital, and to send in their names to the Board of Governors, before January 1 in each year. Students of Trinity College are not liable to any other payment for instruction in practical midwifery. Other students are required to pay £3 3s. each to the King's Professor, for twelve months' practical instruction, in addition to the hospital maternity fee. The certificates of Sir Patrick Dun's Hospital are recognised by the Royal University and the Conjoint Royal Colleges of England, Ireland, and Scotland.

**CORK STREET FEVER HOSPITAL** is the only special fever hospital in Dublin. It is supported mainly by an annual Government grant, and capitation grants for patients. Regular clinical instruction is given during the winter and summer sessions to those who desire a special course in fevers. All particulars may be obtained on application to the Registrar and Resident Medical Officer.

**NATIONAL CHILDREN'S HOSPITAL** for the treatment of all non-infectious diseases peculiar to children, 87 and 88, Harcourt Street, Dublin. The hospital, with which the Pitt Street Children's Hospital, founded in 1821, was amalgamated, is capable of containing 50 beds for the reception of cases of deformity and all other forms of surgical disease. There is a large general dispensary for extern patients held daily from 10 to 11. Operations are performed on Saturday at 12 o'clock. Practitioners and students can attend on application to Mr. Ormsby.

**DUBLIN ORTHOPÆDIC HOSPITAL**, Great Brunswick Street, containing 40 beds for the treatment of every class of deformities and for the practice of orthopædic surgery. This institution is under the management of Mr. Swan.

**THE ROYAL VICTORIA EYE AND EAR HOSPITAL** consists—until the new combined hospital is erected—of the two institutions which have, heretofore, given special instruction in ophthalmology separately. They are:—(1) St. Mark's Ophthalmic Hospital and Dispensary in Lincoln Place.—This hospital was founded by the late Sir William Wilde, and contains 50 beds. Clinical lectures are delivered on the mornings of Mondays, Tuesdays, Thursdays, and Fridays at 11 o'clock, and operations are performed on Wednesdays and Saturdays at the same hour. (2) National Eye and Ear Infirmary, Molesworth Street.—This hospital contains 80 beds. Clinical instruction in diseases of the eye, including the use of the ophthalmoscope, is given daily. Operations at 12 o'clock. Instruction in aural surgery is also given. Afternoon classes for practical instruction in the use of the ophthalmoscope, &c., and for the demonstration of cases, are formed from time to time by the assistant surgeons.

**THE INCORPORATED DENTAL HOSPITAL, LINCOLN PLACE.**—This handsome hospital, recently erected, is the only special Dental Hospital in Dublin. It is officered by a very strong staff of the leading dental surgeons of Dublin, and has a large *clientele* and extensive practice among the Dublin poor. The fees are £15 15s. for first year's study, and £12 12s. for second, and proportionately smaller fees for shorter periods. We refer our readers to the advertisement in our columns to-day for full information as to the staff.

## IRISH PUBLIC SERVICES.

### THE POOR-LAW MEDICAL SERVICE.

Since the early part of 1899 a vital change has taken place in the Irish Poor-law Medical Service—the service which has, heretofore, absorbed most of the Irish rising medical generation. By the Irish Local Government

Act the administration of the system, the appointment and payment and allocation of duties of medical officers was transferred from the old Board of Guardians, composed in due proportion of members elected by the local voters and members who acted *ex-officio* in virtue of property qualifications, to new boards composed wholly of the elected representatives. This change has had the most disastrous effect upon the service. The *ex-officio* guardians, *i.e.*, the local gentry, were, thereby, eliminated, and the sole control of the service has been transferred to the elected Guardians, who have, we regret to say, sought to place considerations of economy before everything—before the welfare of the poor, and before the just rights of the medical officer. Questions of religion and politics are so rampant on Irish elected Boards that the medical officer who is at variance on these matters with the majority of the Board, who governs him, has not a pleasant life. The Irish Medical Association whose work it is to safeguard the interests and improve the condition of the Poor-law medical officer, considers it an imperative duty to point out to young practitioners the following facts:—(1) That the Poor-law Medical Service is one in which there is no promotion. (2) That it is a service where few facilities exist for original research, and still less for further medical culture, especially in the rural districts. (3) That, while medical education has become wider in its requirements, and more costly and difficult to procure, the same or a less rate of payment given to less educated men forty years ago is still offered, and this, too, at a time when the rural prosperity of the country is less, and consequently lucrative private practice more difficult to obtain. We need go no further than to say that the Irish Poor-law Medical Service is a service to avoid. To all who contemplate entering the Irish Poor-law Service we emphatically say, Don't.

The newly-qualified medical practitioner who may elect to try his luck in the Irish provinces sets his hope in the great majority of instances upon obtaining one or more Poor-law medical appointments in some district where there is hope of private practice. There are 159 workhouses and about 813 dispensary medical officers, besides apothecaries. The number of vacancies that occur annually averages 100. The salary in this service used to average about £114, but is rapidly coming down, and when it is taken into consideration that in the vast majority of rural districts it is necessary to keep one or more horses, the average area being from forty to sixty square miles, it is plain that there will not be a large margin left from the public emoluments.

The medical officer is also *ipso facto* the registrar of births, marriages, and deaths, and medical officer of health for the district, under the Public Health Act passed in 1873 and amended in 1878. The former office, in country districts, yields between £5 and £10 a year, and the emoluments of the latter appointment in very few cases reach £20, averaging about £12. The medical officer is also vaccinator for the locality, and is required to vaccinate everyone who wishes to come. For each patient a fee of 2s. is paid, along with his salary, by the guardians, and the sum total of those fees varies, according to the populousness of the district, from £4 to £100, an average for the provinces being about £10. Despite the miser-

able salary, and the very many discomforts of dispensary life, these appointments are generally eagerly sought for—first, because they afford the new comer a certain, though hardly-earned salary to supplement his private earnings; and secondly, because, if not secured by the new comer, they would of necessity bring a competitor for office into the field, and, inasmuch as private income is of far greater import than public earnings, country medical practitioners are obliged to undertake the public duty in order to maintain the monopoly of their private emoluments.

*Appointments.*—The qualifications required by the Local Government Board are a licence in surgery, in medicine, and in midwifery; but registration in the Medical Register, if effected since the passing of the Medical Act, in 1886, fulfils all requirements. The candidate must also be 23 years of age.

The appointment to both workhouse and dispensary lies with the guardians, who elect by vote. As politics and religious feeling run high in Ireland, these elements enter largely into the election of Poor-law medical officers. Family interest also possesses great weight.

The candidate will do well to bear these facts in mind, as his personal attendance on the day of election will be required, and whatever other qualifications he may have, he will then find that his compatibility in these respects with the majority of the guardians is essential, and accordingly he had better first make himself acquainted with the local peculiarity, whatever it may be, before he enters on his candidature, otherwise, in all probability any expenditure that he may make in the matter will be simply thrown away.

*Duties.*—The duty of the dispensary doctor is twofold. He is to attend his dispensary on a given day or days in the week. Frequently there are two dispensaries in the district, separated from each other by several miles, and he will have perhaps to attend two days a week. He has also to visit at any hour of the day or night a sick person for whose relief a visiting ticket has been issued by a member of the committee or the relieving officer, and to continue his attendance as often as may be necessary to the termination of the case. Moreover, he has a great many registry books to keep and a multitude of returns to make, and in the majority of districts he has to make up all the medicines for the poor.

The pressure of these duties is in a great degree dependent on the goodwill of the guardians. If the medical man be a favourite with his masters they will give him very little trouble with "scarlet runners," as the visiting tickets are, from the colour in which they are printed, humorously called, and will be unwilling to trouble him even with cases deserving of personal attendance.

If, on the other hand, it is his misfortune to differ from the guardians in religion or politics, his position may become impossible. He may be peremptorily summoned in any weather, at any hour, and to any distance, to a case which he may probably find to be altogether trivial, or to a person whom he may know to be perfectly well able to pay.

*Workhouse Hospitals.*—The number of unions in Ireland is 159, to each of which is attached a medical officer, who is appointed and controlled by the board of guardians in the same manner as the dispensary surgeon. The salary is usually better than that of the dispensary doctor, and the duties of a more easy and satisfactory description inasmuch as they are confined to daily attendance at the workhouse hospitals, and no night visits out of doors or any long journeys across the country are involved.

#### THE IRISH LUNACY SERVICE.

This service, at present, affords a comfortable liveli-

hood for 22 Resident Medical Superintendents and 32 Assistants. The Superintendents receive salaries and allowances ranging, according to the number of inmates of the asylum, from £500 to £1,000 a year, and the Assistants receive salaries and emoluments averaging about £200 a year. There are also Visiting Physicians receiving about £120 a year, but this class of officer is being allowed to die out, and no new appointments will be made.

The Superintendents and Assistants are to devote their whole time to their duties and not to take any private practice.

Heretofore the appointments of Medical Superintendents have been in the patronage of the Lord Lieutenant, but, under the new Local Government Act, they will be in the hands of the County Councils, with the proviso that no one shall be appointed who is not a fully registered practitioner with five years' service as Assistant. The Assistant has been, heretofore, appointed by the Board of Governors, and will, in future, be appointed by the Committee of the County Council to which the management of the asylum is entrusted. In addition to these officers, there are, in certain larger asylums, Clinical Residents, who receive about £50 a year and full allowances. These appointments afford excellent introduction to the higher places in the service.

It will be seen that the Irish Lunacy Service is well, but not too well paid, not only for the valuable and responsible services rendered, but for the *désagrémens* of living in a lunatic asylum. It is, however, a service available for only a very few who have political or personal influence to obtain appointments.

#### OTHER APPOINTMENTS.

There are, in addition to those which we have mentioned, certain emoluments open to medical practitioners in special localities. They are:—

1. Attendance on the Royal Irish Constabulary.
2. Attendance on the Coast Guards.
3. Factory Surgeoncies.
4. Attendance upon the depot soldiers who are not otherwise provided for.

The Constabulary are paid for at the rate of 2s. per month for each member of the force on duty in the district, including the wives and children of the men but not of the officers. This includes the supply of medicines. The appointment to this position rests with the Inspector-General of the Royal Irish Constabulary, who usually acts upon the advice of the local District Inspectors as to the convenience of the men, and, of course, the emoluments depend on the number of Constabulary stations and the number of men in each.

*The Coastguard Service.*—The duty of the Medical Officer is to attend the men when sick and to examine candidates either for admission or for superannuation. The fees vary from 6s. to 2s. 6d. per visit. The appointments rest with the Admiralty, but are usually secure for the local Poor-law Medical Officer. In this case, also, the emoluments depend on the number of stations and men.

Factory Surgeoncies are in the gift of the Chief Inspector of Factories in Whitehall, and are, of course, available only in the few districts in which there are factories to inspect. There is a set scale of payment by the factory owner to the inspector for this work, but we believe it is not adhered to, and, in some districts, at all events, the emolument is a matter of arrangement. The amount depends upon the size of the factory, the position being, in Dublin or Belfast or in other large manufacturing centres, a lucrative one, but in other places scarcely worth taking. The attendance on the military depots is not worth mentioning.

*The names of the Professors, Lecturers, and Hospital Staffs of the foregoing Schools and Hospitals, are not included in this place, being found in the advertisement of each Institution, as indicated on next page.*

Royal College of Physicians	51	Meath . . . . .	52
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University of Dublin . . . . .	57	Mater Misericordie . . . . .	52
Royal College of Surgeons . . . . .	57	Adelaide . . . . .	58
Royal College of Science . . . . .	53	Jervis Street . . . . .	51
Queen's College, Cork . . . . .	58	Dr. Steeven's . . . . .	51
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Catholic University . . . . .	57	<i>Special Hospitals:</i>	
<i>General Hospitals:</i>		Rotunda Lying-in . . . . .	58
Royal City of Dublin . . . . .	61	Royal Victoria Eye and Ear . . . . .	58
Sir Patrick Dun's . . . . .	57	National Children's . . . . .	56
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Scotland.

SCOTLAND still maintains her educational system at the high level to which it long ago attained, and, with a considerably less numerous population inhabiting her whole area than that of London alone, supports four venerable and historic Universities, each with an honoured past and a magnificent record. The Universities of Edinburgh, Glasgow, Aberdeen, and St. Andrews have sent forth many illustrious graduates in all the different branches of higher learning; few schools can show more gratifying results, and when the scheme embodied in the magnificent Carnegie bequest is fully elaborated and in working order, still more brilliant results are anticipated. In Edinburgh and Glasgow those who do not aspire to the honour of a University degree can obtain college diplomas and excellent medical teaching from extra-mural schools of almost equal renown.

The inhabitants of Scotland have always evinced a deeply-rooted dislike for constraint; the regulations of their Universities exemplify this. The student in Scotland is his own master; he lives where he likes, dines where he pleases, and can clothe himself in any kind of garment he chooses. In but one of the Universities have students to don gowns. No doubt the great freedom granted to students occasionally leads to unsatisfactory results, but the advantages which accrue from the system may be held to more than counterbalance the drawbacks. The student is only required by the authorities to attend with due regularity various compulsory classes, to give evidence of diligence in his work, and to conduct himself with proper decorum while within the University precincts. Several halls of residence for students have lately been established, but even here the students are their own masters. Absence of residential colleges implies the absence of college fees, and of the invariable large extras incurred by college life.

The co-existence of teaching and degree-granting universities and extra-mural medical schools in Scotland forms one of the most important factors in the system of medical education in the country. That obtainable at the universities is the best of its kind, comprising courses on all branches of special medicine and surgery; at the extra-mural schools the special subjects are perhaps even better treated, as they are taught by specialists themselves. In the way of expense, there is little between the University course and the obligatory curriculum for the Licence of the Colleges. The minimum cost for five years' attendance for the licence may be put down at £120, which includes class and examination fees; and at the universities at £146; a difference of about £25 a year only.

Perhaps the one blot upon the Scottish system of medical education at Universities arises from the plan

adopted at their professional examinations of delegating the examiners' duties to the professors themselves, along with only one coadjutor for each subject. As University students are now allowed to attend one-half of the total number of courses required for graduation outside the University walls, it happens now and again that those who have done so in a subject, upon which they are examined by the professor teaching it, are placed at a disadvantage in not being thoroughly conversant with subjects specially lectured on by examiners during the preceding session. The examining board for the diploma of the Scottish colleges, indeed, is largely made up of the extra-mural lecturers, but the number assigned to each subject is large enough to avoid the examination of a candidate by his own teacher in the majority of instances.

Apart from the educational attractions offered to students of medicine by the Scottish schools, a very important fact aids to explain the reason why so many students from all parts of the Empire enrol their names in their books: the cost of maintenance is less than in England or Ireland. As a general rule the higher the latitude the cheaper is the living in Great Britain. Edinburgh and Glasgow are more economical than London and Dublin; Aberdeen still less expensive.

UNIVERSITY OF EDINBURGH.

Four degrees in medicine are granted: Bachelor of Medicine (M.B.), Bachelor of Surgery (Ch.B.), Doctor of Medicine (M.D.), and Master of Surgery (Ch.M.). The first two must be taken together, the last two may be taken separately.

No one is admitted to the degrees of Bachelor of Medicine and Bachelor of Surgery who has not been engaged in medical and surgical study for five years, after passing a preliminary examination in general knowledge in accordance with the medical ordinances. The degree of M.A. of a British University is held to supersede such preliminary examination. The subjects included in this general examination are English grammar and composition, English history and geography, Latin, arithmetic, and the elements of mathematics, and, in addition, as optional subjects, Greek, French, or German.

The *annus medicus* of each year is held to be constituted by at least two courses of not less than one hundred lectures each, or by one of such course, and two courses of not less than fifty lectures each, exclusive of the clinical courses, in which lectures are given twice a week during prescribed periods. Two years of the five must be spent at the University, the remaining three years at any University of the United Kingdom, or other Universities or Medical Schools recognised by the University Court.

During the first four years the student must attend elementary botany, elementary zoology, physics, practical chemistry, practical physiology, practical pathology, and medical jurisprudence and public health during courses of not less than 2½ months each; practical anatomy during two courses of not less than five months each; chemistry, anatomy, physiology, pathology, surgery; materia medica and therapeutics, medicine, and midwifery and the diseases of women and children during courses of not less than five months each. Eight of these subjects must be taken at a University. He must attend a course of 25 meetings on practical pharmacy in a University or recognised school of medicine, or have dispensed drugs for a period of three months in a hospital or dispensary, or in an establishment recognised by the Pharmaceutical Society. He must attend a nine months' course in clinical medicine and in clinical surgery. During the fifth or final year he must be engaged in clinical study for at least nine months. In all, before graduation he must have attended for at least three years a hospital which accommodates no fewer than 80 patients, and possesses a distinct staff

of physicians and surgeons, and he must have acted as clerk in the medical and dresser in the surgical wards of such a hospital, or the practice of a dispensary, or of a physician or surgeon. He must have had approved opportunities of studying at a hospital, post-mortem examinations, fevers, diseases of children, ophthalmology, vaccination, and mental diseases.

He must personally attend at least twelve cases of labour under the superintendence of a registered medical practitioner, or six such cases, and, for at least three months, the practice of a midwifery hospital in which practical instruction is regularly given.

Every candidate must deliver before the 31st day of March of the year in which he proposes to graduate to the Dean of the Faculty of Medicine—

1. A declaration in his own handwriting that he has completed his twenty-first year, or that he will have done so on or before the day of graduation, under article of apprenticeship to any surgeon or other master. (This declaration, along with a statement of studies, is appended to the schedule for the final examination, and must be signed before the schedule is given in.)

2. A statement of his studies, as well in literature and philosophy as in medicine, accompanied with proper certificates.

Each candidate is examined both in writing and *viva voce* :—

1. Zoology, botany, physics, and chemistry.

2. On anatomy, physiology, and materia medica, and therapeutics.

3. On pathology, medical jurisprudence, and public health,

4. On medicine, surgery, and midwifery.

The examinations in anatomy, chemistry, physiology, botany, and zoology, materia medica, and pathology, are conducted, as far as possible, by demonstration of objects placed before the candidates.

Candidates who are ready to submit to an examination in the subjects comprised in the first division, viz., botany, zoology, physics, and chemistry may be admitted to examination in all or any two of these subjects at any examination held after they have attended a full course in each of the subjects professed.

Candidates who have passed their examination in the subjects in the first division may go up for examination in those of the second division at the end of their third winter session, but may postpone their examination in materia medica and therapeutics until the close of the summer session following.

They may, in a similar way, go up for the subjects of the third division at the end of their fourth winter session, and may postpone their examination in medical jurisprudence and public health until the close of the following summer session.

Candidates who have passed their examinations in the subjects comprised in the first, second, and third divisions may be admitted to examination in the fourth or final division, when they have completed the fifth year of study.

The degree of Doctor of Medicine may be conferred on any candidate who has obtained the degrees of Bachelor of Medicine and Bachelor of Surgery, and who is of the age of twenty-four years, and who produces a certificate of having been engaged, subsequently to his having received the degrees of M.B. and Ch.B., for at least two years in attendance on a hospital, or in scientific work bearing directly on his profession, or in the Military or Naval Medical Services, or in medical or surgical practice. The candidate shall submit to the Faculty of Medicine a thesis certified by him to have been composed by himself, and which shall be approved by the Faculty, on any branch of knowledge comprised in the professional examinations for the degrees of Bachelor of Medicine and Bachelor of Surgery, which he may have made a subject of study after having received those degrees. The candidate will also be examined in clinical medicine and in some of its special departments.

The regulations for the degree of Ch.M. are very similar, the candidate being examined in surgical anatomy, operations on the dead body, clinical surgery, and some of the special branches.

Candidates settled abroad, who cannot appear personally to receive the degree, may, after satisfying the Senatus to that effect, have the degree conferred on them *in absentia*.

Fees: The fee to be paid for the degrees of Bachelor of Medicine and Bachelor of Surgery is twenty-two guineas and the proportion of this sum to be paid by a candidate at each division of the examination is registered from time to time in the University Court. The fee for the degree of Doctor of Medicine or of Master of Surgery is ten guineas.

The total expenses of the curriculum, including examination and matriculation fee, is £146.

Bursaries and Scholarships open for Session 1900, 1901: Among the bursaries and scholarships open during the ensuing year are:—Two Sibbald Bursaries of £30 a year for three years, particulars from Messrs. Mackenzie, Innes and Logan, W.S., 23, Queen St., Edinburgh, before September 15th. Two Thomson Bursaries of £25 for four years, one conferred at each preliminary examination in October and March. Five Grierson Bursaries (natives of Crawford and Leadhills have a preference). Names must be sent in before October 1st. Two John Aitken Carlyle Bursaries of £28 one year for proficiency in class examinations in anatomy and chemistry or physiology. Two Mackenzie Bursaries of £20 in practical anatomy. Renton Bursary of £20, for one year, for students attending classes of natural physiology, mathematics, chemistry, or political economy, who also can show they are in need of pecuniary aid. Names to be sent to secretary before the middle of September. Two Crichton Bursaries of £50, for four years, one competed for at each preliminary examination. Stark Scholarship in Clinical Medicine, of about £100, awarded in July, 1900; Murchison Memorial Scholarship of the interest from £1,000, to take place in Edinburgh in the summer of 1901; Buchanan's Scholarship of £40 10s., for proficiency in midwifery and gynecology, as shown by class work and in the final examination. Other scholarships are:—The James Scott, £42 10s., annually, in midwifery; the Thomson, £40 for four years, in botany, zoology, and elementary mechanics in October; the Ettles, £31 5s. annually to the most distinguished graduate; two Hope Prizes, £30 annually, in chemistry; two Crichton, £100 annually, in anatomy and physiology.

Full particulars of these and of the other prizes may be found in the "University Calendar" (published by Mr. Thin, South Bridge, Edinburgh, price 8s., post free, 3s. 6d.), or the "Medical Programme" (price 2d.) from the same publisher.

Graduation in Science: The University of Edinburgh also possesses a Faculty of Science which may confer two degrees, Bachelor of Science (B.Sc.) and Doctor of Science (D.Sc.) These degrees are given in pure science and in applied science. Candidates for the degree of B.Sc. in pure science must attend at least seven courses of instruction in the subjects selected by them during the course of not less than three academical years. Three of these courses must be on subjects selected by them during the course of not less than three academical years. Three of these courses must be on subjects prescribed for the first science examination, and four on those for the final examination. Four of these courses must be taken in the University of Edinburgh. Among the subjects recognised are chemistry, human anatomy, physiology, zoology, and botany. Graduates as B.Sc. may, after five years, proceed to the degree of D.Sc., undergoing an examination in the subjects chosen, and presenting a thesis founded on original work.

Graduation in Public Health: Similar degrees are conferred in Public Health. Candidates must be graduates in medicine of a university recognised by the University Court, and must matriculate for the year in which they appear for examination. Before proceeding to the first examination they must produce evidence that (1) they have worked for at least twenty hours a week during a period of not less than eight months, after taking their medical degree, in a recognised Public Health Laboratory. Five of these months must be spent consecutively in the Public Health Laboratory of the University of



Edinburgh and (2) have attended a course of lectures on physics, and one, of at least three months' duration, on geology, such as the Senators may approve of.

Candidates for the second examination of B.Sc. in Public Health are not admitted until at least eighteen months have elapsed after having passed M.B., Ch.B., or sooner than six months after the first examination. They must have attended two separate courses of Public Health, or at least forty lectures in each, one dealing with medicine, the other with engineering, each in its relation to public health, in such manner as the Senatus shall determine. They must also have studied practical sanitary work under a Medical Officer of Health for six months, have had three months' clinical instruction in a recognised fever hospital, and three months' instruction in mensuration and drawing.

Full details of the subjects included in the different courses are given in the official programme of the Faculty of Science, which may be obtained from the University (price 2d.).

In a similar manner to that described under degrees in pure science, a B.Sc. may after five years proceed to take the degree of D.Sc. in Public Health.

Fees for Science Degrees: B.Sc., first examination, £3 3s.; B.Sc., second examination, £3 3s.; D.Sc., £10 10s.: total, £16 16s.

University Hall, Edinburgh: In an educational number it is worth while to call attention to the advantages now offered to students coming to Edinburgh to study, in the shape of social residences akin to, though very much less pretentious than, the English University Colleges. During the past six years several buildings have been acquired in Edinburgh for this purpose, in which students can live in a self-governing community. In each house there are private studies with or without bedrooms, and common sitting and dining rooms. The charges vary from 7s. 6d. to 22s. 6d. per week. The residents elect a treasurer from among their number, who acts as intermediary between them and the housekeeper or servants. It is a satisfactory indication of the comfort of the Hall that several graduates now live in it and are willing to help or coach the undergraduates for moderate fees. To gain admission two references must be produced from past or present residents. These are considered and voted on at a house meeting. In all disputed points Professor Geddes is the referee, while Dr. Ricardo Stephens is the rent treasurer, who will supply any further information required. The Hall is an admirable place for parents to send their sons to. Any unruly member may be expelled by a meeting of the residents similar to that held for elective purposes.

Medical School for Women in Edinburgh: The Medical Teaching of Women in Edinburgh is carried on by the Scottish Association for the Medical Education of Women (the Secretary, Minto House, Chambers Street). The classes are conducted by the lecturers of the Medical School of the Royal Colleges, and qualify both for the Edinburgh University degree and for the Licence of the Triple Board. The classes are for women alone. The University of Edinburgh does not recognise certificates presented by female candidates for mixed classes without special cause shown.

#### UNIVERSITY OF GLASGOW.

The University of Glasgow is both a teaching and an examining body, but admits to examination only those candidates whose course conforms to its own regulations. Within certain limits provision is made for accepting instructions given by recognised medical schools and teachers; but eight of the subjects other than clinical must be taken in this or some other recognised University entitled to confer the degree of M.D., and at least two years of the course must be taken in Glasgow University. Under the new regulations, laid down in Ordinance No. 14, Glasgow No. 1, of the Commissioners under the Universities (Scotland) Act, 1889, four degrees, open both to men and to women are conferred—M.B. and Ch.B. (always conjointly), M.D. and Ch.M. A preliminary examination must be passed in (1) English, (2) Latin, (3) Elementary Mathematics, and (4) Greek,

French, or German, with possible option to students whose native tongue is not English in the case of the fourth subject, and on passing students must register in the books of the General Medical Council. By a regulation recently enacted, it is no longer compulsory to pass in all the four preliminary subjects at once, and they may now be passed at two stages. For M.B. and Ch.B. a curriculum of five years is required.

The fees for M.B. and Ch.B. are £23 2s., and the present fee for hospital attendance is £21. The fee for M.D. is £10 10s., and for Ch.M. is £10 10s.

Bursaries and prizes to the annual amount of about £900 are appropriated to medical students, including an Arthur bursary for women, £25 for three years.

Several bursaries open to students in any faculty are not infrequently held by medical students, and scholarships and fellowships to the annual amount of £1,600 may be held by medical students who have gone through the Arts course.

QUEEN MARGARET COLLEGE FOR WOMEN.—Founded in 1883 (by the Glasgow Association for the Higher Education of Women, which was formed in 1877 with the object of bringing university instruction, or its equivalent, within the reach of women), Queen Margaret College in 1890 added to its Faculty of Arts a School of Medicine for Women. This was organised entirely on university lines, and with the view of preparing for university degrees; and when, in 1892, in consequence of the Ordinance of the University Commissioners authorising the Scottish Universities to admit women to instruction and graduation, Queen Margaret College became the Women's Department of the University of Glasgow, its classes in medicine taken previously to its incorporation with the University were recognised as preparing for the degree. A full course of study for M.B. and Ch.B. is given by University Professors and Lecturers, with excellent facilities for hospital and dispensary work in the Royal Infirmary and other hospitals. A Hall of Residence for the students was founded six years ago.

#### UNIVERSITY OF ABERDEEN.

The University of Aberdeen possesses under its charters the amplest privileges claimed or enjoyed by any academical institution. It confers degrees in the five faculties of Arts, Science, Divinity, Law, and Medicine. It also grants diplomas in Public Health, Agriculture, and in Education. It is, moreover, a teaching body equipped with twelve distinct chairs in the various branches of medicine and surgery, besides a Lectureship in Tropical Medicine. The majority of the professors devote their whole time to the work of the chairs. There are fully-equipped laboratories, the accommodation for which has recently undergone considerable extension. The degrees of M.B. and Ch.B. are conferred together; they cannot be obtained separately. The curriculum of study is nearly the same as in the University of Edinburgh; the regulations in the preceding columns will therefore apply here. Two years must be passed at Aberdeen. With regard to fees, each candidate for the degrees of M.B. and Ch.B. must pay a fee of £5 5s. in respect of each of the first three professional examinations, and £7 7s. for the final examination. Class fees, £3 3s. each. Total cost, exclusive of the fees for degrees, is about £100. Besides the Royal Infirmary, students have the opportunity of attending several other local institutions where special courses of instruction are given. Perpetual fee for hospital practice is only £6. The professional examinations are held twice in each year, namely, in March and July, directly after the close of the winter and summer sessions.

BURSARIES.—Bursaries, Scholarships, and Fellowships to the number of fifty, and of the annual value of over £1,150, may be held by students of medicine. See "University" Calendar.

THE DEGREE OF M.D.—The degree of Doctor of Medicine may be conferred on any candidate who has obtained the degrees of M.B. and C.M. (Old Regulations), is of the age of twenty-four years, and has been engaged subsequently to his having received the degree of M.B. for two years in attendance in a hospital, or in military or naval medical service, or in medical or surgical

practice, and has presented a thesis which has been approved of by the Medical Faculty. Candidates for the degree of M.D. (New Regulations) are required to pass an examination in clinical medicine in addition to presenting a thesis. Similar regulations apply to a degree of Ch.M. (Master of Surgery).

A Diploma in Public Health is conferred after examination on graduates in medicine of any university in the United Kingdom.—Regulations may be seen in the Calendar, or obtained on application to the Secretary of the Medical Faculty.

**ABERDEEN ROYAL INFIRMARY.**—This is a well equipped institution, containing 240 beds, and affords excellent opportunities for clinical study to students at the Aberdeen University. The city, moreover, offers inducement in the way of cheaper living and comparative quiet to that obtained in Edinburgh and Glasgow, and will doubtless be preferred by some on this account.

#### ST. ANDREWS UNIVERSITY.

##### UNITED COLLEGE ST. ANDREWS AND UNIVERSITY COLLEGE, DUNDEE.

This University (session opens October 9th) grants the degrees of M.B., Ch.B., M.D., and Ch.M., and also a diploma in Public Health. The degrees of the University are open to either sex. For the degree of M.B., Ch.B. two of the five years of medical study must be spent in the University of St. Andrews; the remaining three may be spent in any University of the United Kingdom, or in any foreign, Indian, or Colonial University recognised for the purpose by the University Court, or in such medical schools or under such teachers as may be recognised for the purpose by the University Court. The preliminary examination and the professional examinations are of the same character as in the other Scottish Universities.

*University College, Dundee*, was affiliated and made to form part of the University of St. Andrews on January 15th, 1897, and the whole medical curriculum may be taken in the College. The United College, St. Andrews, offers classes for the first two years of professional study.

#### BURSARIES AND SCHOLARSHIPS.

**UNITED COLLEGE, ST. ANDREWS.**—Two Berry bursaries of £40 tenable for three years, open to men for arts, science, or medicine. Fourteen Taylor-Thompson bursaries £50 to £30 tenable for one year, partly for two, open to women only proceeding to graduate in medicine.

**UNIVERSITY COLLEGE, DUNDEE.**—Eleven entrance bursaries of £15, open to men or women for arts, science, or medicine, tenable for one year. Four £20 and three £15 second year bursaries for men or women in arts, science, or medicine, tenable for one year. Four £20 and two £15 third year bursaries for men or women in arts, science, or medicine, tenable for one year. Two Educational Trust Bursaries of £25, tenable for three years. Applicants must have attended a public or State aided school in Dundee for at least one year before examination. Bute Bursary annual income from £1,000 (men only).

**PRELIMINARY EXAMINATIONS.**—The dates of the next two examinations are September 27th, 1901, and March 28th, 1902. Schedules (obtainable from the Secretary of the University) to be returned filled up, and fees paid by September 14th, 1901, or March 9th, 1902.

*Fees for Degrees.*—Total fees for M.B., Ch.B., are the same as at other Scottish Universities, i.e., 22 guineas (payable in instalments). Fee for the degree of M.D., and also for that of Ch.M., is ten guineas in each case. For the Diploma of Public Health Examinations the fee is £5 5s. for each of the two examinations. The diploma is granted on special examination to graduates in medicine of any University of the United Kingdom.

**UNITED COLLEGE, ST. ANDREWS.—Class Fees.**—The fee payable in each of the following separate classes is 3 guineas, viz., in Chemistry, Practical Chemistry, Physics, Zoology, Botany, Physiology, Practical Physiology, Anatomy, Practical Anatomy.

**UNIVERSITY COLLEGE, DUNDEE.—Class Fees.**—The fee payable in each of the following separate classes is 3 guineas, viz., in Chemistry, Practical Chemistry, Physics, Zoology, Botany, Physiology, Practical Physio-

logy, Anatomy, Practical Anatomy, Materia Medica, Practical Pharmacy, Pathology, Practical Pathology and Bacteriology, Medical Jurisprudence and Public Health, Medicine, Surgery, Operative Surgery and Midwifery.

In Clinical Medicine, Clinical Surgery, Ophthalmology, Diseases of Throat and Ear, and Mental Diseases the class fees are 2 guineas each, and in Fevers 1 guinea. For the Chemistry required for the D.P.H. the fee is 7 guineas. A special class is also held for the D.P.H., for which the fee is 3 guineas.

**DUNDEE ROYAL ASYLUM.**—The appointments include a qualified resident assistant and two resident clinical clerks. Clinical instruction is given.

Further information will be found in the Calendar of the University, published by Messrs. Blackwood and Sons, Edinburgh, or can be had of the Dean of the Medical Faculty, Professor Weymouth Reid, F.R.S.

**DUNDEE ROYAL INFIRMARY.**—The Infirmary contains 300 beds, with a special ward for the treatment of children. Three resident qualified assistants are appointed annually. Clinical clerks and dressers are attached to the physicians and surgeons, and students are appointed to assist in the post-mortem room. Out-patients are seen daily at 9 a.m. The instruction given at the Infirmary is recognised for purposes of graduation by the Scotch Universities, the University of London, the University of Cambridge, the Royal University of Ireland, and by the Royal Colleges of England and Scotland. Hospital Ticket for the Infirmary, £2 2s. each session, or £3 3s. a year. Further information on application to the Medical Superintendent.

**ST. MUNGO'S COLLEGE AND GLASGOW ROYAL INFIRMARY.**—This college was incorporated in 1889 under its new title, being formerly known as the Glasgow Royal Infirmary School of Medicine. The Medical Faculty occupies buildings erected for the purposes of the medical school in the grounds of the hospital, and the laboratories, museums, and lecture rooms are of the most approved description. Attendance on the classes in St. Mungo's College qualifies for the medical degrees of the Universities and the medical and surgical colleges in accordance with their regulations.

The Royal Infirmary, which is at the service of the College for teaching purposes, is one of the largest general hospitals in the kingdom. It has 612 beds available for clinical instruction, including an ophthalmic department, and it has special wards for diseases peculiar to women, for venereal diseases, erysipelas, burns, and diseases of the throat. At the dispensary special advice and treatment are given in diseases of the eye, ear, teeth, and skin, in addition to the large and varied number of ordinary medical and surgical cases—about 62,000 per annum—which in a great industrial centre daily require attention. Students at the college and hospital get the benefit of dispensary experience free of charge, and no better or wider field for seeing hospital practice and receiving clinical experience can be found than in the Glasgow Royal Infirmary.

**Appointments:** All appointments are open. There are five physicians' and seven surgeons' assistants who obtain free board and residence in the hospital and act in the capacity of house physicians and house surgeons, and there is an assistant to the gynaecologist who boards but does not reside in the hospital. There is also a house surgeon for the ophthalmic department. These appointments are made for six months, and are open to gentlemen who have a legal qualification in medicine and surgery. Clerks and dressers are appointed by the visiting physicians and surgeons. From the large number of cases of acute diseases and accidents of varied character received, these appointments are valuable to students. In the pathological department assistants are also appointed by the pathologist.

**Fees:** The fees for Lectures, including Hospital attendance necessary for candidates for the Diplomas of the English, Scotch, and Irish Colleges of Physicians and Surgeons, amount to £72.

**ANDERSON'S COLLEGE MEDICAL SCHOOL, GLASGOW.**—New and excellently equipped buildings were opened in October, 1877, in Dumbarton Road, immediately to the west of the entrance to the Western Infirmary, and

within four minutes' walk of the University. Extensive laboratory accommodation is provided for practical anatomy, practical chemistry, practical botany, practical zoology, practical physiology, practical pharmacy, operative surgery, and hygiene and public health. There are also provided a library and reading room, and a students' recreation room. The buildings are constructed upon the most approved modern principles. The dissecting room is open in winter from 9 a.m. to 6 p.m., and in summer from 6 a.m. to 6 p.m. These students are assisted in their dissection by the professor and demonstrators, by whom daily examinations and demonstrations on the parts dissected are conducted. The supply of subjects is ample, and students are consequently provided with parts as soon as they may be ready for them. The dissecting room is provided with a complete series of dissecting specimens mounted in plaster of Paris illustrating the anatomy of the human body. There is also a large Bone Room, furnished with complete sets of painted and unpainted bones.

**Dental Curriculum:** Students studying with a view to the dental diploma can obtain instruction in the following subjects: Physics, chemistry, anatomy, physiology, surgery, practice of medicine, and materia medica. The special dental courses may be obtained in the Dental School, 5, St. Vincent Street, Glasgow.

**Fees:** Fees for hospital practice and clinical lectures, first year, £10 10s.; second year, £10 10s.; afterwards free. For six months, £6 6s.; three months, £4 4s. Students who have paid 20 guineas at another hospital for its perpetual ticket are admitted six months for £2 2s.; or one year for £3 3s. Vaccination certificate, recognised by Privy Council, £1 1s.

#### THE COLLEGES.

The Royal College of Physicians of Edinburgh, the Royal College of Surgeons of Edinburgh, and the Faculty of Physicians and Surgeons of Glasgow have made arrangements by which, after a series of examinations, the student may obtain the diplomas of the co-operating bodies.

The holders thereof are enabled to register three diplomas under the Medical Acts, viz., Licentiate of the Royal College of Physicians of Edinburgh, Licentiate of the Royal College of Surgeons of Edinburgh, and Licentiate of the Faculty of Physicians and Surgeons of Glasgow. The diplomas are also recognised by the Army, Navy, and other public bodies.

The three co-operating bodies grant their *single* qualifications only to candidates who are already registered as possessing another and opposite qualification in medicine or surgery, as the case may be.

**REGULATIONS OF THE JOINT BOARD OF THE ROYAL COLLEGE OF PHYSICIANS OF EDINBURGH AND THE ROYAL COLLEGE OF SURGEONS OF EDINBURGH AND THE FACULTY OF PHYSICIANS AND SURGEONS, GLASGOW.**—The candidate must produce certificates of having attended the following separate and distinct course of lectures, the certificate distinguishing the sessions and the schools in which the courses were severally attended. Anatomy, one course, six months. Practical anatomy, twelve months. Chemistry, one course, six months. Practical or analytical chemistry, one course, three months. Materia medica, one course, three months. Physiology, one course, six months. Practice of medicine, one course, six months. Clinical medicine, nine months. Principles and practice of surgery, one course, six months. Clinical surgery, nine months. Midwifery and diseases of women and children, one course, three months. Medical jurisprudence, one course, three months. Pathological anatomy, one course, three months. The candidates must also produce the following certificates:—(a) Of having attended not less than six cases of labour under the superintendence of the practitioner who signs the certificates, who must be a registered medical practitioner. (b) Of having attended for three months, instruction in practical pharmacy. The certificate to be signed by the teacher, who must be a member of the Pharmaceutical Society of Great Britain, of the Superintendent of the laboratory of a public hospital or dispensary, or a registered practitioner who dispenses medicine to his patients, or a teacher to a class of practical pharmacy. (c) Of having

attended for twenty-four months the medical and surgical practice of a public general hospital, containing on an average at least eighty patients, and possessing distinct staffs of physicians and of surgeons. (d) Of having attended, for six months, the practice of a public dispensary specially recognised by any of the co-operating bodies; of having been engaged for six months as visit-assistant to a registered medical practitioner. (e) Of having been instructed in vaccination.

**First Examination, Fee £5.**—The first examination shall embrace chemistry, comprising the following particulars:—Chemical physics, heat, light, and electricity, the principal non-metallic and metallic elements, and their more common combinations, also the leading alcohols, organic acids, ethers, carbohydrates, and alkaloids; the candidates will also be examined practically in testing; physics and elementary biology. The first examination shall take place not sooner than the end of the first year, including a winter and summer session. Candidates who desire to enter for the first professional examination must apply to the Inspector of Certificates on or before the Friday preceding the day of examination, and must produce certificates of attendance on one course of chemistry, one course of practical chemistry, one course of anatomy, and six months' practical anatomy.

**Second Examination, Fee £5.**—The second examination shall embrace anatomy and physiology, and shall not take place before the termination of the summer session of the second year of study. Candidates must produce to the inspector certificates of attendance on the prescribed courses of anatomy, practical anatomy, and physiology.

**Third Examination, Fee £5.**—Comprises the subjects of pathology, materia medica, and pharmacology and advanced anatomy.

**Final Examination, Fee £15.**—The final examination shall embrace the principles and practice of medicine (including therapeutics and medical anatomy, clinical medicine); the principles and practice of surgery (including surgical anatomy and surgical pathology); clinical surgery; midwifery and gynaecology, medical jurisprudence and hygiene; and shall not take place before the termination of the full period of study.

**Subjects of Preliminary Education:** (1) English language, including grammar and composition; (2) Latin, including grammar, translation from specific authors, and translation of easy passage not taken from such authors; (3) elements of mathematics, comprising (a) arithmetic, including vulgar and decimal fractions; (b) algebra, including simple equations; (c) geometry, including the first two books of Euclid; (4) elementary mechanics of solids and fluids, comprising the elements of statics, dynamics, and hydrostatics; (5) one of the following optional subjects:—(a) Greek; (b) French; (c) German; (d) Italian; (e) any other modern language; (f) logic; (g) botany; (h) zoology; (i) elementary chemistry.

**Qualification in Public Health:** The College of Physicians, in association with the Royal College of Surgeons of Edinburgh and the Faculty of Physicians and Surgeons of Glasgow, confers a certificate of competency in public health. The examinations are held in April and October. Fee, £10 10s.

For the special regulations of the Royal College of Surgeons of Edinburgh, intending candidates should apply to Mr. James Robertson, 48, George Square, Edinburgh; and for those of the Royal College of Physicians, to Dr. E. W. Philip, 45, Charlotte Square.

The Fellowship of the Royal College of Physicians of Edinburgh is conferred only by election, and the candidate must have been a member of the college for at least one year previously, and have attained the age of twenty-five years.

The membership is conferred only on licentiates of the college or graduates of a British or Irish university after an examination in medicine and therapeutics, and in any other branch of medical science to be selected by the candidate. Under certain conditions as to age and professional standing, candidates may, however, be admitted without examination to the licence of E.C.P.Ed.

The licence, or single qualification in medicine, is conferred on candidates who already possess a recognised qualification in surgery. The examinations of this licence are held on the first Wednesday of each month, save those of September and October, on medicine, materia medica, midwifery, and medical jurisprudence. The fee is £15 15s., and intending candidates should communicate with the Secretary of the College at least eight days before the date of examination.

The Fellowship of the Royal College of Surgeons of Edinburgh is conferred (except under certain conditions as to age and professional standing) only on candidates who have passed a special examination, and have previously obtained a diploma from the college, or from either of the Colleges of Surgeons of England or Ireland, or the Faculty of Physicians and Surgeons of Glasgow, or the surgical degrees of the Universities of Great Britain, and who are twenty-five years of age. The subjects for examination for those who are already Licentiates of the College are on the principles and practice of surgery, clinical and operative surgery, and one optional subject.

Those who are not Licentiates of this College: on principles and practice of surgery, clinical and operative surgery, surgical anatomy, and one optional subject; and in such supplementary subjects as have not, in an adequate manner, been included in the examination for the registrable surgical qualification possessed by such candidates, and which are required in the examination for Licentiates of this College.

The optional subjects shall embrace: (a) Surgery, special branches; (b) advanced anatomy and physiology; (c) surgical pathology and morbid anatomy; (d) midwifery and gynecological medicine and surgery; (e) medical jurisprudence and hygiene; (f) practice of medicine and therapeutics. The examinations are written, oral, and practical. Three weeks' notice must be given to Mr. James Robertson, from whom full particulars as to certificates required may be obtained. The fee is £30 for those who hold the diploma of Licentiate of the College, and £45 to others (no stamp duty is payable on the diploma). Registered practitioners, aged not less than 40, who have been in practice for not less than ten years, and who have highly distinguished themselves by original investigations, may under special circumstances be elected without examination. Women are not admitted to the Fellowship.

**LICENCE.**—The examination embraces the principles and practice of surgery (including operative surgery and surgical pathology), clinical surgery, and surgical anatomy, and shall not take place before the termination of the full period of study. Fee £15 15s.

**WOOD BURSARY.**—The examination for the Wood Bursary, of £60 per annum, tenable for three years, will take place on October 21st and 22nd, at the college. The subjects will be found in our advertising columns.

**DENTAL DIPLOMA.**—Every candidate for the dental diploma must have attended the general lectures and courses of instruction required at a university or an established medical or dental school recognised by the College as qualifying for the diploma in surgery. The fee is £10 10s.

**EDINBURGH ROYAL INFIRMARY.**—Clinical instruction is afforded at this institution, which contains 780 beds in the building, and 10 beds in a convalescent home under the supervision of professors of the university, and the ordinary physicians and surgeons of the infirmary. Special instruction is given on diseases of women, physical diagnosis, and diseases of the eye, ear, throat and teeth. Separate wards are devoted to venereal diseases, diseases of women, diseases of eye, also to cases of incidental delirium or insanity, and three wards are specially set apart for clinical instruction to women students. Post-mortem examinations are conducted in the anatomical theatre by the pathologists, who also give practical instruction in pathological anatomy and histology. The perpetual fee, on one payment, £12; the annual fee, £6 6s.; half-yearly, £4 4s.; quarterly, £2 2s.; monthly, £1 1s. Separate payments amounting to £12 12s. entitle the student to a perpetual ticket. No fees are payable for any surgical or medical appointment.

The appointments are as follows:—

1. Resident physicians and surgeons are appointed and live in the house free of charge. There is no salary. The appointment is for six months, but may be renewed at the end of that period by special recommendation.

2. Special non-resident clerks (in the special subjects and for out-patient work) are appointed for six months. These also may be similarly renewed.

3. Clerks and dressers are appointed by the surgeons and physicians. These are open to all students and junior practitioners holding hospital tickets.

4. Assistants in the pathological department are appointed by the pathologists to conduct post-mortem examinations in the anatomical theatre.

**SCHOOL OF MEDICINE OF THE ROYAL COLLEGES, EDINBURGH.**—This school, established in 1505, is constituted by over fifty lecturers especially licensed by the colleges.

The lectures qualify for the University of Edinburgh, and other universities, the Royal Colleges of Physicians and Surgeons of Edinburgh, London, and Dublin, and the other medical and surgical boards.

The minimum cost of the education in the School of Medicine for the triple qualifications of physician and surgeon from the Royal Colleges of Physicians and Surgeons of Edinburgh and the faculty of Physicians and Surgeons of Glasgow, including the fees for the joint examinations, is about £115, which is payable by yearly instalments during the period of study.

The Winter Session opens October 2nd. The secretary, Mr. R. N. Ramsay, 24, Forest Road, Edinburgh, will forward the School Calendar *gratis* to inquirers.

#### POST-GRADUATE COURSES IN SCOTLAND.

In Edinburgh a number of permanent post-graduate courses continue more or less continuously throughout the year. Among those open to or especially for post-graduates are:—

1. Ophthalmology: Daily at the Royal Infirmary. 2. Ophthalmoscopy: Dr. George Mackay, Eye Dispensary, Chambers Street, fee £2 2s.; Dr. W. G. Sym, Eye, Ear, and Throat Infirmary, Cambridge Street, fee £2 2s. 3. Aural Surgery, &c.: Dr. MacBride and assistants, Royal Infirmary; Dr. Hunter Mackenzie, Eye, Ear, and Throat Infirmary, fee £2 2s. 4. Pathological Bacteriology: Dr. T. Shennan, Surgeons' Hall, fee £2 2s. 5. Dermatology: Drs. Allan Jamieson and Norman Walker, fee £3 3s.; Dr. Stewart Stirling, Skin Dispensary, Lauriston Place, fee £1 1s. 6. Diseases of Children: Sick Children's Hospital, Dr. John Thomson; minor surgical diseases of children, Mr. H. J. Stiles, fee £2 2s. 7. Chest diseases: Dr. R. W. Philip, Victoria Hospital and Dispensary, fee £2 2s. 8. Gynecology: Dr. Brewis, fee £2 2s. 9. The Demonstrations on Modern Gastric Methods, by Dr. A. Lockhart Gillespie, fee £2 2s., available at any time during the year on the request of a sufficient number of post-graduates. All these courses are of short duration, varying in length from three to six weeks. The Honorary Secretary, Post-Graduate Courses, Surgeons' Hall, will supply a full syllabus on application.

In Glasgow, special courses in ear diseases are held in November and May at Anderson's College, and post-graduate courses in pathology and bacteriology at the University from September 13th to October 12th, 1901.

#### PARTNERSHIPS, ASSISTANTSHIPS, &c.

Information is often sought by recently qualified men and by their parents as to the most convenient plan by which to get into the position to commence general practice. To such we offer the following hints:—

*Partnerships in General Practice.*—In Ireland and Scotland it is generally found that private practice worth having only exists in large towns; elsewhere in these two divisions of the Kingdom medical men live cheaply on the emoluments of their appointments. In England it is different; appointments are subordinate to private practice everywhere, and the succession to a practice can be very generally secured by purchase, which is not the case in either Ireland or Scotland. Although there are in England practices that cannot be bought, it is evident that no money will command the highest class of practice, which is a personal thing attaching to a man and cannot therefore be transferred. Partnerships are

regarded as safe introductions to practice; but apart from the notoriously high charges for admissions to partnerships, we regard them as greatly over-estimated in value. To obtain a partnership a considerable amount of capital is indispensable, for the following reasons:—

1. A share in a partnership, if of any value, is not likely to be had for less than £1,000.
2. A junior partner has to live upon his own resources until the money earned in the practice after the date of his entry is paid, i.e., until the first year's bills have gone out and have been honoured by the patients.

**Assistantships.**—An assistantship is a capital discipline for any man, especially as assistants in medical practice are now treated more as gentlemen and *confreres*; but the salary obtainable is more a question of actual experience than of the diplomas held. To act as "locum tenens" it is essential that previous experience of practice should have been obtained, a full knowledge of dispensing being absolutely necessary, dress and personal appearance going also a long way towards securing an engagement.

**Ship Appointments.**—There are certain appointments, which are usually obtained without much difficulty, and are often inquired about. The Postal Service to and between the West India Islands is an unhealthy service, but is not a bad one for men who can exercise a fair amount of self-control. The salary and perquisites are equal to about £200 a year, with board and lodging. If a man lives through a few years, and does not fall a victim to the many temptations which present themselves, he may ultimately get promoted into the Cape or Brazilian lines, which is regarded as a very good service. To the Peninsular and Oriental Steamship Company it is almost impossible to obtain entrance except by the personal influence of the directors; the same may be almost said of other steamship lines.

#### END OF THE EDUCATIONAL NUMBER.

#### THE OPENING OF THE LONDON MEDICAL SCHOOLS.

Charing Cross Hospital Medical School—Wednesday, Oct. 2nd.  
Introductory Address by Prof. J. W. Taylor, F.R.C.S.  
Dental Hospital of London—Tuesday, Oct. 1st.  
Guy's Hospital Medical School—Tuesday, Oct. 1st.  
King's College, London, Medical Faculty—Tuesday, Oct. 1st.  
London Hospital Medical College—Tuesday, Oct. 1st.  
Middlesex Hospital Medical School—Tuesday, Oct. 1st. Introductory Address by Mr. T. H. Kellock, F.R.C.S.  
Royal Free Hospital School of Medicine for Women—Tuesday, Oct. 1st. Introductory Address by Dr. F. W. Andrewes.  
St. Bartholomew's Hospital and College—Tuesday, Oct. 1st.  
St. George's Hospital Medical School—Tuesday, Oct. 1st at 4 p.m.  
Introductory Address by Dr. P. W. Latham.  
St. Mary's Hospital Medical School—Tuesday, Oct. 1st.  
St. Thomas's Hospital Medical College—Wednesday, Oct. 2nd, at 3 p.m. Prizes distributed by Major-Gen. Ian Hamilton, K.C.B.  
University College Medical School—Tuesday, Oct. 1st, at 4 p.m.  
Introductory Address by Prof. J. Eisien Russell.  
Westminster Hospital Medical School—Tuesday, Oct. 1st.

#### PROVINCES.

University of Birmingham—Tuesday, Oct. 1st.  
Bristol, University College—Tuesday, Oct. 1st.  
Cardiff, University School of Medicine—Monday, Oct. 7th.  
Durham University School of Medicine—Tuesday, Oct. 1st.  
Liverpool University College—Tuesday, Oct. 1st.  
Manchester, Owens College—Tuesday, Oct. 1st.  
Sheffield, University College—Tuesday, Oct. 1st. Sir T. Barton, Bart.  
The Yorkshire College—Tuesday, Oct. 1st.

#### IRELAND.

Adelaide Medical and Surgical Hospitals, Dublin.  
Catholic University Medical School, Dublin—Nov. 2nd.  
City of Dublin Hospital—Tuesday, Oct. 1st.  
Dr. Steeven's Hospital—Monday, Oct. 7th.  
Dublin University—Oct. 1st.  
Meath Hospital—Tuesday, Oct. 1st, at 4.30 p.m. Introductory Address by Mr. William Taylor, on Oct. 14th, 4.30 p.m.  
Mercer's Hospital—Tuesday, Oct. 1st.  
St. Vincent's Hospital—Oct. 1st. Introductory Lecture by Dr. Cox, 4.30 p.m.  
Queen's College, Cork—Monday, Oct. 21st.  
Richmond, Whitworth, and Hardwicke Hospitals—Tuesday, Oct. 1st.  
Royal Col. of Surgeons in Ireland Schools of Surgery—Tuesday, Oct. 1st.  
Trinity College School of Physic, Dublin, Dissecting Rooms, &c.—First week in October: Lectures begin first week November.

#### SCOTLAND.

Aberdeen University—Tuesday, Oct. 15th.  
Dundee University College—Wednesday, Oct. 9th.  
Edinburgh University—Oct. 15th.

Edinburgh School of Medicine, Rooms, and Laboratories, Tuesday, Oct. 1st.  
Edinburgh School of Medicine for Women—Tuesday, Oct. 15th.  
Glasgow, Anderson's College Medical School—Thursday, Oct. 17th.  
Glasgow, Queen Margaret College School of Medicine for Women—Oct. 17th.  
Glasgow University—Thursday, Oct. 17th.  
Glasgow, St. Mungo's College—Thursday, Oct. 17th.  
Glasgow Royal Infirmary—Thursday, Oct. 17th.  
Royal Colleges, Edinburgh—Tuesday, Oct. 15th.  
St. Andrews University—Wednesday, Oct. 9th.

#### The Opening of the Medical Schools.

WITH the commencement of October comes the annual opening of the metropolitan and provincial schools of medicine. In London the session commences at St. Thomas's with a prize distribution on October 2nd by Major-General Sir Ian Hamilton, K.C.B., with the annual dinner, at 6.30 p.m., at the Hotel Métropole, Mr. H. H. Clutton in the chair. Guy's Hospital opens on October 1st with a house-dinner of the Students' Club, tickets to be obtained of the secretary. On Saturday, the 5th, Sir Samuel Wilks, Bart., F.R.S., will preside at the first meeting of the Physical Society, to be held in the new Physiological Theatre, when a paper will be read by Mr. S. W. MacIlwaine on "Disease and its Causation." St. George's has an introductory address on October 1st, at 4 p.m., by Dr. T. W. Latham, and in the evening the annual dinner will be held at the Hotel Métropole, with Mr. Warrington Haward in the chair. Westminster begins its session on October 1st, and has its annual dinner on the 4th, under the chairmanship of Mr. Charles Stonham, F.R.C.S. University College Hospital has a lecture on the 1st, at 4 p.m., by Professor J. Risien Russell. The Past and Present Students' Dinner is held, at 6.30, at the Hotel Cecil, with Sir Douglas Powell, Bart., as president. St. Bartholomew begins on October 1st with a dinner, at 6.30, in the Great Hall, Mr. W. J. Walsham, F.R.C.S., in the chair. Charing Cross opens on the 2nd with an address from Professor J. W. Taylor, F.R.C.S., of the University of Birmingham. The Old Students' Dinner will take place on the 22nd of the month at the Hotel Cecil. St. Mary's has an address on the 2nd from Dr. G. W. Hill, the Aural Surgeon, and a dinner on the 3rd at the Hotel Métropole, Col. A. B. R. Myles in the chair. Lord Howard de Walden distributes the prizes at Middlesex, after an address by Mr. T. H. Kellock, F.R.C.S. The annual dinner takes place the same evening at the Trocadero, 7 p.m., with Mr. Bland-Sutton in the chair. The London commences on the 1st, and has its Old Students' Dinner in the Library, under the presidency of Dr. F. J. P. Daly. King's College has a dinner on the 1st at the Hotel Cecil, with Mr. Paul Swain, F.R.C.S., in the chair. The Royal Free School of Medicine for Women has an introductory address on October 1st, at 4 p.m., delivered by Dr. F. W. Andrewes. The London School of Tropical Medicine commences on October 1st, the Dental Hospital, and the National Dental Hospital and College on the same day.

#### PROVINCES.

University of Birmingham:—Session commences October 1st.  
University College, Bristol:—Session commences October 1st.  
University College, Cardiff:—Session commences October 7th.  
Yorkshire College, Leeds:—Session commences Tuesday, October 1st. Sir W. S. Church, Bart., M.D., F.R.C.P., is announced to deliver the introductory address on the following day.  
University of Durham:—The session in the Medical Faculty commences October 1st.  
University College, Liverpool:—Session commences October 1st. The opening address will be

delivered and the prizes distributed on Saturday, October 12th, by Professor Lodge, of Birmingham.

Owens College, Manchester:—Session commences October 1st.

University College, Sheffield:—Session commences October 1st, when Sir Thomas Barlow, Bart., K.C.V.O., will deliver an introductory address.

#### SCOTLAND.

University of Aberdeen:—Session commences October 15th.

University of St. Andrews (United Colleges of St. Andrews and University College, Dundee):—Session commences October 9th.

University of Edinburgh:—Session commences October 15th.

University of Glasgow:—Session commences October 17th.

Anderson's College, Glasgow:—Session commences October 17th.

St. Mungo's College, Glasgow:—Session commences October 17th.

Queen Margaret College, Glasgow (for women):—Session commences October 17th.

#### IRELAND.

Queen's College, Belfast:—Session commences October 15th.

Queen's College, Cork:—Session commences October 17. The lectures commence on October 21st.

University of Dublin:—Session commences October 10th.

Royal College of Surgeons in Ireland:—Session commences October 1st.

### Notes on Current Topics.

#### The Attempted Assassination of the President of the United States.

THE whole civilised world has been shocked by the news of a murderous outrage inflicted on the person of Mr. McKinley, the President of the United States. The facts are simple. In the course of a reception held at Buffalo the President, according to custom, shook hands with a large number of citizens. One of the latter, an American, named Czolgosz, of German extraction, concealed a revolver in the right hand, which was covered with a handkerchief and had the appearance of being bandaged. As the President grasped his left hand, the assassin fired twice with his right hand in contact with the body of his victim. Of the two shots thus fired at close quarters, one glanced off the sternum and was discovered shortly afterwards under the skin by the President himself. The second bullet penetrated the abdomen five inches below the left nipple, and one and-a-half inches to the left of the median line. The abdomen was opened in the line of the bullet wound, and it was found that the missile had penetrated the stomach. The wounds of entry and exit in that organ were sutured, and as the bullet could not be found, the abdominal wound was closed. The operation took place on the 6th, a few hours after the injury, which was inflicted about four o'clock in the afternoon. The surgical reports have since been satisfactory, as the fever is not high, namely, 102.5° F. on the evening of the 8th. It is satisfactory to note there has been no sign of peritonitis. The Röntgen rays have not yet

been called into requisition. Under the circumstances there is good reason to hope that the promptitude with which the resources of modern surgery were applied in this case will be rewarded by the complete recovery of the distinguished patient. That the issue may be favourable is the prayer of civilised Christendom.

#### The Local Government Board and Professor Koch.

AN important circular order has been issued by the Local Government Board with regard to the control of tuberculous meat and milk. The recent declaration of Professor Koch as to the non-transmissibility of tuberculous disease from the lower animals to man has been seized upon as a pretext for objection to a number of irksome restrictions on the part of farmers, butchers, cattle dealers, dairymen, and others. For once in a way, Mr. Balfour's Government has risen to the occasion where a medical issue of vast national importance has been raised. They have appointed a Royal Commission to inquire whether tuberculosis in animals (why not "lower" animals?) and man is one and the same disease; whether animals and man can be reciprocally infected with it; under what conditions, if at all, the transmission of the disease from animals to man takes place; and what are the circumstances, favourable or unfavourable to such transmission. Pending the result of that inquiry the Local Government Board have wisely issued a warning to local authorities that there should be no relaxation on their part or that of their officers in the taking of proper measures for dealing with milk from tuberculous cows and with tuberculous meat which may be intended for the food of man. With the view of rendering the action of local authorities in seizing tuberculous meat more uniform, the Board urge once more the general adoption of the well-known recommendations of the Royal Commission on Tuberculosis, which reported in 1898. They also remark on the importance of anyone who is to act as a meat inspector possessing proper qualifications for that office. They suggest that the local authority shall satisfy themselves that any person thus appointed has the necessary knowledge. This advice is excellent, but it may be doubted whether it is not more or less a counsel of perfection. To be able to inspect meat scientifically demands a close acquaintance with comparative anatomy and pathology, to say nothing of bacteriology and minor matters. Such a combination of knowledge is hardly likely to be found except in a member of the medical profession who had devoted special attention to the subject. In our opinion the proper course in all great centres of the meat trade would be to appoint one or more qualified medical men, with a properly equipped laboratory and a staff of skilled inspectors. It is to be hoped that the present order of the Local Government Board will have a salutary effect throughout the United Kingdom, and will, to a great extent, neutralise the harm likely to ensue from Professor

Koch's apparently hasty and ill-supported declaration of belief.

### An Australian Medical Officer's Experience in South Africa.

THERE is an interesting story going the round of medical circles in Sydney concerning a South African experience of Mr. R. Scott Skirving, the late consulting surgeon to the Australian contingents at the war. The narrative so well illustrates the enormous difficulties that beset the care of the sick and wounded in war that it is worth repeating, especially as it incidentally exemplifies the able assistance afforded the mother country by the colonies. Mr. Skirving found himself in charge of ten wounded men and about fifty sick on the south side of the Zand river, on the line of march towards Kroonstadt. In obedience to orders he started off with his men in bullock waggons; the only stores available consisted of one or two bottles of brandy, some cases of Lazenby's soups, some tins of condensed milk, a little bully beef, and a few biscuits. There were no cooking pots, and no means of carrying water. The only orderly immediately developed enteric fever and Mr. Skirving was thus actually left in sole charge. Single-handed he fed and tended the poor fellows in the most marvellous manner. He gathered wood, dug out the fire trenches, cooked all the food he could commandeer from far and near, served out the meals to the men lying in the waggons, administered hypodermics, supplied the thirsty with drink and gave medicine to the sick; how it was possible for him to have stood the physical fatigue incidental to all this is a mystery, but he is described as having found great enjoyment in the manual labour so necessary to keep his charges alive. His chief difficulty was in getting sufficient water for the men and for the cooking. His kitchen utensils consisted of two old galvanised iron buckets which he commandeered from the Kaffir bullock drivers, and he devised a means of conveyance for the water by using the little water firkins of the Kaffirs. By the help of brandy and opium all went fairly well for a day or two, when suddenly Mr. Skirving received orders to return forthwith. This was a hard trial to the sick and wounded, but worse yet was to befall them. On returning to the Zand six of the waggons were taken away, and the sick and wounded were packed like sardines into the remaining five, and once more jolted off. Nothing daunted, Mr. Skirving stuck to his work, and with unwearied patience finally reached the railway and safely deposited his wearied charges in a train, the boiling water of the engine being promptly taken over for the purpose of refreshing the sick men with some much-needed hot soup. To feed, doctor, and nurse over sixty sick and wounded men for several days together, with no stores and no utensils, is a very heavy task for one individual, and Australia may well be proud of Mr. R. Scott Skirving, the late Consulting Surgeon to the Australian contingent.

### Quackery in Germany.

THE official records of the City of Berlin furnish some curious information of the flagrant manner in which quackery and imposture are allowed to flourish in Germany. Sixty per cent. of the arrant pretenders who, under the guise of benefacting mankind, dupe the more than foolish citizens of Berlin are shown to have been ordinary day labourers. These impudent and ignorant "healers," "bone-setters," and "nature doctors" base their claims to medical recognition on their assertion that they possess certain mysterious virtues unattainable by qualified doctors. The usual nonsense is put forward that they heal where the medical man only causes pain, and in that way they must be therefore more fit to practise medicine, midwifery, and surgery. Only 40 per cent. of these quacks have had an elementary school education, and of the female portion about 58 per cent. have been servant-girls. It is, unfortunately, only too true that if a medical man exposes these quacks the basest of motives are at once imputed to him, and the thanks of the medical world are therefore especially due to Professor Tschlenoff of Bern, for his fearless attack on the increasing number of arrant impostors now infesting Germany. Individuals who see no harm in consulting quacks may be reminded that in Berlin, about 30 per cent. of these quacks have a criminal record.

### The Agitation against Expensive Asylums.

AMONG the Wakefield Guardians, as elsewhere, there is persistent agitation against the extravagance which still continues in the erection of our new asylums. We do not say that this agitation is wrong, far from it, but we wish it were more rational and directed on better lines, and to some more sure and certain purpose. We fear, however, that most of it is mere froth, and that little good will come of it. The very men who agitate in this fashion would be guilty of the same wicked extravagance were the power put in their hands. If the money that has been wasted on showy buildings had been properly spent on good diet, liberal treatment, and the best means for the cure of the insane, it would not have cost the interest on the money which has been spent on these costly piles of architecture, and it would certainly have been more likely to have added to the curative results. What our asylums want more than a pathological department is a clinical department, where schemes of collective investigation would be continually on foot, such as the treatment of epilepsy, the dietetic treatment of the insane, and so on.

### The Royal Commission upon Tuberculosis.

THE Government have appointed a Royal Commission to sift the question of the transmissibility of tuberculosis from the lower animals to man. Their prompt action will command the approval of the medical profession. To the United Kingdom is generally conceded the front rank in practical preventive medicine. It is fitting, therefore, that the

recent revolutionary doctrine announced by Professor Koch at the Tuberculosis Congress in London should be forthwith investigated by the leading scientific authorities in this country. The list of those appointed was published in the *London Gazette* for September 3rd. It stated that the King had been pleased to issue a commission under His Majesty's sign manual, appointing the following members of the new commission: Sir Michael Foster, K.C.B., M.D., F.R.S., Cambridge University; Professor Sims Woodhead, Cambridge University; Professor Sydney Martin, University College, London; Professor John McFadyean, M.B., C.M., F.R.S.E., Royal Veterinary College; and Professor Robert Boyce, University College, Liverpool. This representative commission is armed with full powers to secure full evidence, and the result of their labours may be awaited with confidence. A jury of that stamp could hardly fail to return a conclusive verdict. Their first sitting will probably be in October.

#### Gelatin in Therapeutics.

In February of this year Geraldini published four cases of aortic aneurysm in which he had subcutaneously injected sterile solutions of gelatin with benefit. Though instances of the employment of gelatin in this manner have been reported in which no perceptible improvement has resulted, on the other hand, a number of observers have experienced more or less favourable results, and the first practitioner who used gelatin as a styptic in the human subject was Dr. Carnot, who injected solutions into the nose of a patient with severe epistaxis, with the result that the hæmorrhage was immediately arrested, and he also was successful in the case of a deep razor cut of the hand. It must, however, be acknowledged that Carnot is credited with the belief that subcutaneous injections are dangerous, and that he prefers calcium chloride. It has been calculated that gelatin has been employed in about 500 cases, and the results have been encouraging if its employment in aneurysms is not taken into account. Hahn is reported (*Munch. Med. Woch.*, 1900, p. 1,459) to have administered large quantities of gelatin in a case of hæmaturia, directing the patient to take it with all the food that he ate during the day, and Dr. J. Sailer, in the *Therapeutic Gazette* for August, states that he finds patients prefer to take the gelatin warmed in liquid form. The credit of introducing the injection of gelatin for aneurysm rests with Lancereaux, of Paris.

#### Mortality of Children.

SUCH of our readers as take an interest in the mortality of children, especially in great cities, cannot have failed to notice how many deaths in childhood are uncertified. The significance of this fact is seen when it is known that the great majority of the uncertified deaths occur in children that are insured in one or more of the many burial societies. We approve of insurance in childhood, and the system of small weekly payments is well calculated to pro-

mote thrift. In principle nothing could be more praiseworthy than making provision for the child's future whilst the parents are capable of earning a wage in excess of the wants of their mode of life. But the principle, admirable as it is and fruitful in blessing, is so carried out that insurance becomes an ever-present temptation to the parents to neglect the child. Every visit of the collector reminds them that the child is an expense, and that its death secures a sum of money which to them is large, and at once ends the weekly payments, which are not always convenient. The remedy for such a condition of affairs is to be found in requiring an inquest on the body of every infant whose death is not certified by a physician in attendance from the development of acute symptoms. As a further protection for these poor, helpless little ones no insurance money should be payable in any case in which the body gave evidence of neglect. More than once we have seen every viscus in an infant's body healthy, and yet every limb and every viscus telling in silent eloquence of starvation. To some parents of a naturally callous nature insurance, without safeguards, is a premium for killing their children—a reward for inflicting the most cruel of deaths, the most cowardly form of murder—one in which they may pocket the reward of their evil acts without risking the neck in the gallows. Public health bodies, preventive medicine associations, medical societies generally should interest themselves on the question. We profess horror at the barbarous rites of Moloch, where for a few minutes the babe suffered its death agony, and we complacently live in the higher civilisation that allows inhuman parents to prolong the death agony of the babe for weeks or months, to listen with callous indifference to the cry of hunger day after day until the babe becomes too feeble to appeal for mercy and dies of exhaustion that inhuman parents may escape the death penalty. The law requires that parents should perform their duties towards their children. But it never occurred to our law-makers that a condition of affairs would arise in which the neglect of the primary duty of a parent of providing sufficient suitable food for the child would be rewarded with a money payment. We think too highly of our legislators to imagine that they would tolerate the present condition of affairs for a day if they knew the evils of the system. And we think too highly of their ability to imagine that they cannot find a remedy for this dreadful state of things. The cry—the hunger cry—of the starving babes calls on them to end this criminal state of affairs in the name of our common humanity.

#### Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, September 7th, 1901.

THE *Monatsch. f. Pr. Dermat.* 326 has an article by Professor UNNA ON

THE TREATMENT OF CARCINOMA.

In it he groups together the chemical substances that



appear to have a specific influence on carcinoma, and which in chronic cases and in the case of patients who dread operative measures may be recommended. The writer has employed them with a certain good effect, first of all in lupus of the face, and then occasionally in the more rapidly growing cancer originating in sebaceous warts and birth marks. First of all is the Paquelin cautery, used not for general cauterisation, but in a sieve-like manner, burning points with the point of the cautery; the good effect of these appears to proceed from the products given off from the tissues burnt. Excellent results were also obtained from resorcin in substance or in the form of plaster as well as applications made with 5 per cent. resorcin spirit. Benzoic acid also, either alone or in combination with resorcin in a 1 to 5 per cent. alcoholic solution, was efficacious, especially in rodent ulcer. He has also had good effects from an arsenic salicyl. cannabis gauze plaster (acid arsen. ext. cannabis over 5 per cent. acid salicyl. 20 to 1 m.) in carcinoma of the skin of various origins. There has been here a similar electric action as in the simple salicyl. cannabis plaster on lupus tissues. The suspected tissue ulcerates quickly; the sound tissue in between remains sound longer.

In general, Prof. Unna first of all applies the resorcin gauze plaster. If some nodules remain unaffected they are pricked with the Paquelin cautery, as are also indolent ulcerated surfaces. The plaster is then reapplied strengthened with resorcin powder. If the carcinoma is already deeply ulcerated, the cautery point is at once applied, or the ulceration furthered by the arsenic salicyl. plaster, and the healing up waited for under the use of resorcin plaster or resorcin benzoic acid fumes.

Hr. Bochner has published a dissertation on the

#### TREATMENT OF ACUTE MIDDLE EAR SUPPURATION.

On the basis of twenty-four cases treated in a garrison hospital, the author expresses a very favourable judgment on the dry treatment of the disease. Disinfection or destruction of the excretion of suppuration is effected either by injection of antiseptic solution through the external passages or the eustachian tube, or by the insufflation of powder into the external passages or through the perforation opening.

Catheterisation in the Politzer treatment by blowing in air does harm as often as good even when followed by temporary improvement in hearing. Too much interference after paracentesis is condemned. But as the secretion must be removed and fresh infection must be avoided dry treatment is recommended. The auditory passage must be carefully wiped with a probe armed with sterilised wadding; a strip of gauze is then to be passed in as far on the tympanum and the canal closed with a pledget of lint. As often as the wadding is soaked through with secretion or at least twice a day the ear is to be cleaned fresh and fresh gauze introduced. In many cases a daily change of dressing is enough, especially when a sufficient quantity of gauze is introduced. With such measures sixty patients in the hospital have been discharged after an average detention of twenty-two to twenty-three days, and complication on the side of the mastoid process has only arisen in one case.

Such excellent results must compel at least a consideration of the method of treatment described.

### Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, September 7th, 1901.

#### PSYCHOTOPOGRAPHY AND FLECHSIG.

BIANCHI is inclined to challenge Flechsig with regard to his topography of the brain, and considers many of his theories only an extension of other associated functions, and not new areas as affirmed by Flechsig in his anatomical delimitation.

Bianchi supports his contention with experiments and clinical facts, while Flechsig demonstrates anatomical fibrous relations as proof of his arguments. The anterior margin of the occipito-parietal region is undeniably

visual in man, which is necessary for the higher function of reading. From the simple perception of light in the region of the fissura calcarnina of the cuneus, and the occipital poles the functions may be inferred to be connected with the motor action of the eyeball. In the front of this area, again, we have associated the graphic or symbolic zone. The intermediate space is occupied by the motor centre of the upper arm, which makes the whole area a very complicated combination to reduce to its several elements. Again, the third frontal convolution is credited with the motor of speech, which must stand in the same relation to the muscles of articulation, mastication, phonation, and mimicry, as the arm to the centre of graphic motion or symbolism. The architectural plan of evolution seems to be in a dorso-ventral direction.

This view is supported by the visual zone, which is a pre-rolandic development exhibited in the progress of man, evolved from the senso-motor zone. The frontal lobes, physiologically speaking, may be considered the connection of all sensory and motor movements in the grey matter of other parts of the brain, and therefore the centre of physiological fusion of perceptions in the concrete figure which may be ultimately evolved. Consciousness and sensation, as well as reflex, preside in the frontal convolutions, and, therefore, inhibitory action cannot be excluded.

#### EPILEPSY AND MEMORY.

Bonhoeffer drew attention to a case of epilepsy with disturbed consciousness, yet memory persisted. The father was a psychotic and his brother suffered from migraine. From a child the patient had suffered from convulsive twitchings. He finally developed into an incendiary with epilepsy, while his memory was good. Bonhoeffer thought this corresponded to dreaming where the memory was quite vivid after the act.

#### A NEW SYMPTOM IN EPILEPSY.

Ceni observes that the normal temperature falls from 36 deg. to 34 deg. cent. before an attack sometimes in half an hour to an hour before the attack. This hypothermia does not occur when restored to consciousness again, although it may be irregular and not so constant as the crisis. He considers this strong proof in favour of the proximate cause being of an auto-toxic nature.

### Literature.

#### MONTI'S MODERN PATHOLOGY. (a)

THIS work was awarded the prize at the Fondazione Cagnola competition held in 1897 on the following theme, proposed by the Royal Lombard Institute, "What influence has the doctrine of the proliferation of cells beyond the normal, exercised on the pathology of man? What has that of the pathogenic microbes? Contrast the two doctrines with others older. The advantages of both in the treatment of human infirmities."

Professor Monti shows in his book a very full acquaintance with the pathological literature, both old and recent, of his own and other countries. He traces the development of the theories of cellular proliferation and of the pathogenic microbes from their beginnings, and shows how in each case, great discoveries were generally preceded by vague intuitions of their truth, and brought about by the discovery of improved apparatus and improved technique.

The book consists of six chapters.

Chapter I. treats of cellular pathology; the proliferation of cells and its results, hypertrophy, regeneration of tissues and inflammation.

In the section on inflammation the source of the cellular elements of the exudation is well treated.

Credit is given to Addison for having, in 1843, first formulated the doctrine of diapedesis, usually attributed to Cohnheim. It is further pointed out that "even

(a) "The Fundamental Data of Modern Pathology." By Dr. Achille Monti. Translated by J. G. Eyre, New Sydenham Society. London: H. K. Lewis.

Cohnheim's famous experiment, to which so much importance is attributed as a proof of diaporesis, was performed by Augustus Waller in 1839, and was accurately described, with all its details, in two notes published by him in 1846." There is a short account of the theories of the origin of tumours, and we may note that Professor Monti, in spite of all that has been written in recent years as to their parasitic origin, regards the question of the aetiology of tumours as still remaining unsolved.

Chapter II. deals with the doctrine of pathogenic microbes. It begins with the statement, "The doctrine of pathogenic microbes was found by Agostino Bassi, a Lodogian physician born in 1773." In support of this, Bassi's work on the parasitic nature of the muscardine of silkworms and other writings of his are quoted. There is little doubt that Bassi did foresee the discoveries of modern times, though neither in his own day nor for many years afterwards were his views accepted. The predisposing causes of microbial diseases are also alluded to, and it is pointed out that fatigue, as well as atmospheric and other influences which have been long recognised by clinicians as having more or less causal connection with disease, have been proved to have the effect in lower animals of rendering them liable to certain microbial infections to which, under ordinary circumstances, they are immune. There are also short accounts of the toxins and of immunity.

Chapters III. and IV. are historical, dealing with the doctrine which preceded those which form the chief subject-matter of the book.

Chapter V. deals mainly with the histo-pathological diagnosis of neoplasms, which is treated of very briefly. We agree generally with the statements made as to the scope and usefulness of this method of diagnosis. In many cases which are clinically doubtful the histological structure of the diseased tissue leads to an absolutely certain diagnosis; but we think that in examination of this sort the pathologist may sometimes arrive at a wrong conclusion, unless he takes into account the history and clinical features of the case. In referring to the so-called deciduo-cellular sarcoma it is stated that in this disease "the decidual elements left implanted in the uterus vegetate and form tufts similar to chorionic villi."

We entirely disagree with this view. All modern opinion is opposed, and we believe rightly opposed, to the view that the decidual cells take any part in the formation of this condition, and, moreover, tufts similar to chorionic villi do not occur in it.

The sixth and last chapter deals with the doctrine of pathogenic microbes in its relation to the diagnosis and treatment of disease, and is, from the point of view of practical medicine and surgery, the most important in the book.

The relation of the different pathogenic microbes to disease, and the methods of their recognition, are briefly stated.

We cannot agree that the recognition of diphtheria bacilli in cover-glass preparations from the membrane by their tendency to form groups or clumps in which the individual elements are arranged parallel to each other, is so easy as the author states. Nor, inasmuch as this organism is frequently present in healthy throats, can it be maintained that the discovery of the diphtheria bacillus is sufficient for a certain diagnosis of diphtheria.

In his allusions to serum diagnosis of typhoid fever the author recommends a dilution of one in ten. This is, of course, the dilution which was originally used in this method, but experience has shown that a reaction in this dilution has not at all as much diagnostic value as a reaction obtained with a dilution of one in fifty. We believe that the latter is the dilution generally employed at the present time.

With regard to the method of taking blood for examination in pyæmia, though we have sometimes succeeded in demonstrating organisms in a single drop of blood, we prefer, where possible, to use a larger quantity, taken by means of a sterile syringe from a superficial vein. This is a method which presents little difficulty, and

gives a better chance of success. There is less risk, too, of accidental contamination than in taking blood by simple puncture of the skin. The account of the malaria parasites is, considering the necessary brevity, excellent, and the same may be said of the sections on aæpsis and serum therapy. As far as the narrow limits of the book allow, it deals with its subjects in an admirable manner, and affords an excellent summary of our knowledge of them at the date of its appearance.

There are copious and useful footnote references to the literature of the subject. Altogether, the book is one worthy of high commendation, and a valuable addition to pathological literature, especially as to the parts which deal with history and criticism.

We cannot commend the work of the translator, perhaps because the translation is too literal. For instance, in the reference to preparation of material for histological examinations we read "the inclusions are made in celloidin," &c. We assume "the inclusions are made" is a literal translation, but it is not an expression used in English. Other similar instances occur throughout the book.

## Correspondence.

[We do not hold ourselves responsible for the opinions of our correspondents.]

### THE TREATMENT OF GOUT.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The treatment of gout is a matter of interest to everyone who practises medicine, whether general or special. As a factor in many skin diseases, every dermatologist sooner or later learns to recognise the importance of gout, both regular or irregular. It is not a little curious, however, to find that almost the whole pathology and treatment of gout furnishes the field for a host of conflicting theories and practices. Apart from the fact that the specific gouty deposit consists of relatively insoluble sodium biurate, and that uric acid is an essential feature, the whole chemistry of the condition, including the very existence of the soluble quadrurates is full of doubts, difficulties, and contradiction. If that be the case with an exact science like chemistry what may one expect from an inexact science like that of medicine, inexact, that is to say, in that much of its procedure is founded on propositions incapable of proof on imperfectly investigated phenomena. The chemists have tried to furnish uric acid solvents in their laboratories, but the claims of lithium piperazine and a host of other so-called gout specifics have not withstood the test of experience. We stand very much where Sydenham did when called upon to treat acute gout. So, too, with diet, every physician has his own dietary, and there is no scientific law on the subject. As to alcohol, most medical men exclude wines, and thereby, to my mind, lose a valuable remedy, inasmuch as the sufferer from chronic or advanced gout is often in a state of bodily debility. Hence the value of a glass of sound port or sherry. The evil lies not in quality but in quantity.

It is curious to see how the writers of learned and voluminous treatises upon gout lapse into brevity when they arrive at treatment. So much remains to be learned about the disease and its manifold ramifications that some of the bedside experiences of your medical readers could hardly fail to be of value.—I am, Sir, yours truly,

DAVID WALSH.

Grosvenor Street, London, W., Sept. 7, 1901.

### PASTEUR TREATMENT OF HYDROPHOBIA.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—A letter from a medical man at Hove has been going the round of the newspapers. It is a violent attack upon the Pasteur treatment of hydrophobia, and shows such lack of reasoning power as to merit your attention. The writer clearly thinks that strong assertion of personal opinion takes the place of argument,

and that formal proof is unnecessary. His other logical method is simply to attribute to his opponents the worst possible motives. By a combination of these uncultured processes he produces a letter of abuse worthy of the intellectual powers of a Billingsgate fish porter. He begins by saying that reports have appeared in the Paris papers this summer of an alarming increase of hydrophobia. The discrepancies in these reports, he says, "are so glaring as to render them altogether absurd and unreliable." This statement he gives boldly, without reference or proof. He then ascribes their probable origin to an attempt to create another hydrophobia scare in the interests of the Pasteur Institute. His next assertion is that it has been "fully proved" by Lutaud of Paris, by Dr. Dolan, and others that the Pasteur anti-rabic system is useless and dangerous.

One can only say that if a thing is "fully proved" it must be true. It is impossible to believe, however, that the scientific world has wilfully shut its eyes to the logical proof of an important matter that has been before it for some years. One would rather ask Mr. J. H. Thornton, for that is the writer's name, what he means by "fully proved." Judging from the general tone of his communication, one would imagine that in using the phrase he is simply begging the question by stating as a fact what he should prove by the formal processes of logical reasoning.

The rest of his letter is devoted to the accusation that the serum treatment of hydrophobia is simply kept alive because there is "money in it." An innuendo of that kind could be cast at almost every discovery in therapeutics past and present.

A practical training in the elementary methods of correct reasoning would prevent many a medical man from flaunting false conclusions in the face of the public.

I am, sir, yours truly,

SCRUTATOR.

Brighton, August 31st, 1901.

[We have seen the letter alluded to by our correspondent and agree with him so far that its writer does not support his strongly expressed views by any attempt at evidence. Neither does he act with dignity, in our opinion, by attributing sordid motives to the followers and supporters of so distinguished a scientific man as Pasteur. When a medical man writes to the lay newspapers the least he can do is to state his facts and conclusions clearly and temperately, and to avoid personalities that do not affect the main issue.—ED.]

#### THE BIOLOGICAL TEST.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I did not wring my hands when I read your warning to anti-vivisectionists. I smiled the smile of the incredulous. A relative of my own was recently the subject of just such an obscure lung complaint as that which you use as an example. He consulted many specialists; some diagnosed pneumonia, others tuberculosis. A portion of his sputum was inoculated into guinea-pigs, and they died of tuberculosis, it was declared. The disease progressed so rapidly that hope was abandoned. He went to the south coast to die; fell into the hands of a physician who disputed the diagnosis of tuberculosis, notwithstanding the dead guinea-pigs, and treated him for pneumonia. In two months my relative was well. They say at the laboratory that by all the rules of medicine my relative ought to have died of tuberculosis as the animals did; if they did. Why should pneumonia be more easily diagnosed in a dying or dead mouse than in the man from whom the disease was taken? The bacillus of pneumonia (Friedlander) says Sims Woodhead, "sometimes gives rise to pneumonia in mice, guinea-pigs and dogs, but does not affect rabbits."

The diplococcus of pneumonia (Fraenkel), says Osler, is a wide-spread organism at times present in the mouth secretions of healthy persons. So animals inoculated with such secretions might die and lead one to suppose

that the healthy persons who entertained the bacilli were really the subjects of pneumonia, Dr. Hare in his "Practical Diagnosis," says that "while the presence of tubercle bacilli gives positive evidence, their absence in a given sample of sputum is not negative evidence of an absolute character, for that particular specimen may be free from bacilli or they may have escaped the staining or the eye of the examiner." I am not a bacteriologist, but I think I have read of sputa in which more than one form of pathogenic organism has been found. A patient might have the bacilli of tubercle in his lungs and they might escape the eye of the examiner of the sputum, but the secretions of the mouth might contain, as Osler tells us, the diplococci of pneumonia, and so the physician might be misled into treating his patient for this disease instead of the tuberculosis from which he was really suffering. The mice inoculated with the pneumonia bacilli might be killed by them instead of by the tubercle bacilli, which were not found.

The clinical signs of the various forms of lung disease are, in the vast majority of cases, quite sufficient to enable us to make our diagnosis; where they are not so, it is my conviction that such experiments on mice or guinea-pigs are more likely to hinder than help us.

I am, Sir, yours truly,

EDWARD BERDOE, L.R.C.P.(E.), M.R.C.S.

September 6th, 1901.

[We insert the foregoing letter, but at the same time must point out its conflicting internal evidence. The "pneumonia" spoken of must clearly have been chronic, or Dr. Berdoe's relative would not have had time to consult many specialists and go to the seaside. Chronic pneumonia is another name for "fibroid phthisis," and the only absolute means of diagnosing the tuberculous onset is by proving the presence of the bacillus either microscopically or by inoculation. We are at a loss to know how the special treatment of the chronic "pneumonia" could have ensured the salvation of the patient. What were the measures used that would not equally have applied to phthisis? Dr. Berdoe seems to overlook the fact that tubercle bacilli disappear from lungs that recover. The presence of great numbers of pneumonia cocci in sputum, though not conclusive is yet strongly suggestive of a pneumonic origin. We still hold that not a few lung conditions present the greatest difficulty in diagnosis, and that the physician who refuses to avail himself of the evidence afforded by inoculation experiments in such cases is withholding from his patient the advantages of the most highly skilled modern treatment.—ED. M. P. & C.]

#### Sanitary Inspectors' Association.

THE Autumnal Conference of the Sanitary Inspectors Association was held in London last week, and during the meeting the members visited the Sewage Works at Crossness, and several factories of interest, including the new Limehouse Works of the well-known disinfectant manufacturers, the "Sanitas" Company, Limited. On the previous day, by request of the Council, a paper on "Disinfection and Disinfectants" was communicated to the Conference by Mr. C. T. Kingzett, F.I.C., F.C.S., and the members were subsequently afforded the opportunity of inspecting the processes of manufacture of the several disinfectant liquids and powders named "Sanitas," "Okol," "Creocide," "Soldis," and "Formitas," as also the patent Sulphur Candles and the various Formic fumigating, drain testing and other appliances which are produced by the "Sanitas" Company. The members of the Association were also entertained at a luncheon presided over by Sir James Crichton Browne, M.D., F.R.S., who impressed upon them the importance of their duties and of the proper employment of reliable disinfectants for preventing the spread of disease.

## Notices to Correspondents, Short Letters, &c.

**✉** CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

**REPRINTS.**—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the publisher or printer before the type has been distributed. This should be done when returning corrected proofs.

**ORIGINAL ARTICLES or LETTERS** intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication, but as evidence of identity.

### NOTICE TO HOSPITAL AND COLLEGE DEANS.

THE Editor desires to thank those gentlemen attached to the various Medical Schools and Hospitals for supplying him with the information from which the foregoing pages have been composed.

### NOTICE TO OUR READERS.

As this number is mainly devoted to information necessary for students intending to join one or other of the various Medical Colleges, and for those who, having passed their curriculum, are about to enter the ranks of the profession, much of the ordinary matter which usually fills our columns is necessarily deferred till next week. Should any of our readers desire to present this number to a patient or friend who contemplates sending his son to a medical college, our Publisher will be happy to supply him with a duplicate free of cost on receipt of address.

### DIRECT REPRESENTATION ON THE GENERAL MEDICAL COUNCIL.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—May I venture to ask you to do me the favour of allowing me to announce that I mean again to be a candidate for the post of Direct Representative for Scotland in the General Medical Council? On a future occasion I hope to be able fully to explain my views on current medical topics to the Scottish profession, which has hitherto so handsomely entrusted their interests in the Council to my hands.

I AM, SIR, YOURS TRULY,  
WILLIAM BRUCE, M.D.,  
Hon. LL.D., Aberdeen University.

Dingwall, N.B., Sept. 7, 1901.

**COUNTRY PRACTITIONER (S. Wales).**—From the symptoms you describe we should suspect syphilis. There would be no harm in making a cautious trial of antisyphilitic remedies.

**P. O. P.**—If you send your patient to an instrument maker for an X-ray photograph you must be prepared for the consequences. There are several qualified specialists who are able to give a skilled opinion upon the resulting radiogram when taken. In medico-legal cases there is the further advantage that their testimony is available in court, while it would as a rule entirely exonerate the practitioner of any blame for bad results.

**F. J. W. (Yorks).**—It seems almost incredible that any practitioner at this time of day should treat a suppurative corn by poultices. There is little wonder that the ankle-joint has been destroyed under such circumstances, and we think you are lucky in having saved the patient's life by amputation. Prompt antiseptic excision and treatment would most likely have prevented the subsequent suffering and danger to life.

### A MODEL DAIRY.

**MISTRESS:** Have you got me the butter I sent you for, Bridget? Bridget: Well, indade, ma'am, I have not. Lidn't I go all the way to the crematorium, and they hadn't a scrap.

**DENTAL STUDENT.**—The latest book on the subject is Sewill's "Manual of Dental Surgery," a fourth edition of which has just made its appearance. From a cursory glance, we should say that it contains everything likely to be required of you in your course.

**ASHFORD (Middlesex).**—1. Send a specimen of the sputum to a bacteriological laboratory. 2. Use your antitoxin at once in large doses. Do not wait for a confirmation of diagnosis. 3. Children sleeping or playing together when one is affected with diphtheria often escape infection in a marvellous manner. 4. A qualified nurse is a necessity.

**MARLOW.**—The occurrence is not uncommon at this season of the year, even when the bite of the insect is inflicted upon a healthy person. A short while since we saw the bite of some small insect (not a bee or wasp) on the back of the hand of a strong man followed by remarkable results. There was formation of pus locally, from up the arm, sharp rigors, fever, loss of appetite, and prostration. The explanation seems to be that the insect has inoculated some specially virulent micro-organism with its puncture. Treatment is prompt incision, and antiseptic application with rest and quinine internally.

**AN ANXIOUS G.P.**—We need hardly remind you that it is unsafe to take the testimony of patients as to what has been said to them by another practitioner. The best and most straightforward course would be, in our opinion, for you to go and ask the medical man in question what are the facts of the case. You will then have the satisfaction of knowing that there can be no misunderstanding in your relations to him in the matter.

**PUBLIC HEALTH.**—Plums in themselves are not injurious; that is to say, if neither unripe nor rotten. The injurious element appears to be town dust, for diarrhoea is not caused by plums eaten in the country. The whole question probably hinges upon the organic pollution of the dust of towns by the bowel bacteria of the horse.

## Appointment.

STEVENSON, ROLAND A., L.R.C.P.Lond., M.R.C.S.Eng., Junior Resident Medical Officer at the London Open Air Sanatorium, Pinewood, Berkshire.

## Vacancies.

- British Medical Temperance Association.—Assistant Secretary. Must be a qualified practitioner, a total abstainer, and able to speak in public. Salary £150 per annum, with lecture fees and board and residence. Applications to the Hon. Sec., Dr. Ridge, Carlton House, Enfield. (See advt.)
- Chichester Infirmary.—House Surgeon. Salary £100, with board, lodging, and washing. The House Surgeon is required to lecture to the nursing probationers. Applications to the Secretary.
- Essex County Asylum, Brentwood.—Junior Assistant Medical Officer, under 26 years of age. Salary £140. Applications to the Medical Superintendent.
- Glasgow University.—Additional Examinership in Medicine and Science. Annual emolument £30. Duties to commence in January, 1902. (See advt.)
- Great Northern Central Hospital, London.—Vacancies for House Physician, Salary £80 per annum; Junior House Physician, Salary £30. Board, residence, and washing provided in each case. Also Junior House Surgeon, Salary £30, with board, residence, and washing; and a non-resident Assistant House Surgeon, with Salary at rate of £30 per annum, and partial board. Full particulars of these vacancies will be found in our advertisement columns.
- Kaaf-el-Ainy Hospital and School of Medicine, Cairo, Egypt.—Physician to the Hospital and Professor of Clinical Medicine at the School. Salary £E320 per annum and private practice allowed.
- Lancaster County Asylum.—Assistant Medical Officer. Salary £150, rising to £250, with board, washing, and attendance. Applications to the Medical Superintendent.
- London Hospital, Whitechapel.—Surgical Registrar. Salary £100 per annum. Applications to the House Governor before October 3rd.
- North-Eastern Hospital for Children.—Resident Medical Officer. Salary £120, with board, washing, &c. Applications to the Secretary, at the City Offices, 27, Clement's Lane, Lombard Street, London, E.C.
- North Wales Counties Lunatic Asylum, Denbigh.—Second Assistant Medical Officer. Salary £120 per annum, rising to £160, with board, residence, and washing. Applications to the Clerk of the Visiting Committee.
- West Africa.—Two Medical Officers on special Military Expedition. Engagement for six months on a salary of £30 per month, with free rations, &c. Free passages and full pay both ways. Applications to the Private Secretary, Colonial Office, Downing Street, London, S.W.
- Worcester County Asylum.—Third Assistant Medical Officer. Salary commencing at £120, with board, residence, &c. Applications to the Medical Superintendent.

## Birth.

MCCLYMONT.—On Sept. 4th, at 194, High Road, Leyton, the wife of John McClymont, M.D., of a daughter.

## Marriages.

- BRADFORD—LAWSON.—On Sept. 5th, at Kew Parish Church, John Bradford, M.B.Cantab., &c., only son of the late William Bradford, Esq., of Moorbatch, Dorset, to Hannah Lamb (Nancy), youngest daughter of William Lowe Lawson, Esq., of Jersey.
- RICHARDSON—WALLIS.—On Sept. 4th, at St. Peter's Church, Bexhill-on-Sea, Gerald Noble Richardson, B.A.Cantab., only surviving son of Noble Richardson, Esq., of Bombay and Bournemouth, to Ella Mary, eldest daughter of the late Frederic M. Wallis, M.B.C.S., J.P., of Bexhill and Etchingham.
- SMITH—MACNAB.—On Sept. 5th, at George Lane Congregational Chapel, South Woodford, John Smith, M.B., M.R.C.S.Lond., of Stroud Green, London, N., to Christina Cameron Macnab, of Glasgow, daughter of the late John Macnab, of Edinburgh.
- SNELL—GREEN.—On Sept. 4th, at St. Anne's Church, Eastbourne, Sidney H. Snell, M.D., B.S.Lond., &c., of Wandsworth Common, to Emily Hilda, only child of the late William Green, of Durham.
- STEPHEN—DIXON.—On August 29th, at St. Margaret's Church, Brotton, William Anderson Stephen, M.A., M.D., of Loftus-in-Cleveland, to Elizabeth Scarth, eldest daughter of D. W. Dixon, The Hall, Brotton-in-Cleveland.

## Deaths.

- AUST LAWRENCE.—On August 29th, at Bishopsteignton, suddenly, A. E. Aust Lawrence, M.D., of Clifton, aged 53 years.
- HOSFORD.—On August 30th, at Hastings, after a short illness, John Stroud Hosford, L.R.C.P. Edin., &c., of Stratford, Essex.
- THOMSON.—On Sept. 3rd, at Goodwin House, Deal, John Thomson, F.C.S., eldest son of the late John Thomson, M.D., E.N., aged 71.

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## Original Communications.

### SEASIDE SANATORIA FOR CHILDREN FOR THE PREVENTION AND TREATMENT OF SCROFULOUS COMPLAINTS. (a)

By SIR HERMANN WEBER, M.D.,  
F.R.C.P.Lond.,

Consulting Physician to the German Hospital, London; and to the National Hospital for Consumption, Ventnor.

IN former times the so-called scrofulous diseases were much discussed by the medical profession and the public, but comparatively little attention is paid to them at present, while the more fatal pulmonary tuberculosis commands general attention. Yet there is good reason why scrofulous affections should in an equal measure engage our sympathy and attention, firstly, because they are likewise of tuberculous nature and intimately allied to other forms of tuberculosis, and often lead to pulmonary or to acute meningeal tuberculosis; and secondly, because they cause infinite suffering and misery to the patient and often cause death or invalidism or a crippled state for life. By treating scrofulous affections we therefore not only endeavour to cure the existing diseases, but also to prevent pulmonary tuberculosis.

The principal means of cure are: Life in the open air; good food adapted in quality and quantity to the patient's condition; hydrotherapeutic measures, such as bathing in the open sea or in tepid sea water, friction of the body with cold water, &c.; active or passive exercise or rest in the open air, regulated according to the nature of the affection. Surgical treatment is required in some cases, and is more successful in the pure air of the seaside than in inland towns; but the majority of diseases of bones and joints, of enlargements of glands and scrofulous ulcers, heal without active operative interference, though bandages are often indispensable.

Such treatment cannot be carried out at the homes of the children of the poor, and frequently even not at the hospitals of large towns; but in the pure air of the seaside (and also of inland places, especially at high elevations) the treatment, if commenced early, almost always results in complete cure.

Those who are rich can make the most necessary arrangements in private houses or establishments, but the children of the poor have no chance excepting in public sanatoria; and for the great majority of them, sanatoria at the seaside are preferable to those inland, on account of the more vivifying effect of the sea air, which undergoes constant changes by the regular local currents of air and by the stronger general winds, and on account of the facility of bathing in the open sea or in tepid sea water. Experience shows that at the seaside the energy of the nervous

system, the appetite and digestion, and the whole organism are more rapidly improved than at inland localities. Inland sanatoria, however, can likewise be rendered most useful, and are, indeed, preferable in cases of scrofulosis complicated already with pulmonary tuberculosis, or in cases of pulmonary tuberculosis alone, since most of them bear high winds badly. Localities situated at high elevations, as for instance Samaden, exercise a very beneficial influence, not only on pulmonary but on glandular affections, and on the so-called surgical tuberculosis of joints and bones. This remark is, however, not to be understood as if we did not recognise that great results can be obtained at well situated and well managed sanatoria in lower inland regions. Great and welcome lessons, for instance, are to be learnt from the benefit effected by the "Œuvre d'Ormesson," at Ormesson and Villiers-sur-Marne, near Paris.

As the subject is so very large, we will confine ourselves at present to the sea-side sanatoria for children, as means of prevention as well as cure. Although we must attend to diseases already developed, we must, if possible, not wait till the scrofulous or tuberculous disease is already fully established, but must begin our treatment at the first indications, when we can gain in two months what in advanced cases barely can be effected in two years.

The poor children who are most benefited, and who specially require the sanatorium treatment, are those affected with:—1. General weakness and deficient nutrition. 2. Tardy and imperfect recovery from various acute diseases, such as measles, whooping cough, scarlet fever, diphtheria, influenza, &c. 3. Anæmia. 4. Rachitis. 5. Scrofulous and tuberculous swelling of the lymphatic glands. 6. Scrofulous and tuberculous inflammation of the joints, including hip-joint disease and Pott's disease. 7. Adenoid affections of the throat and nose. 8. Scrofulous ophthalmia. 9. Scrofulous skin diseases.

For the treatment of the majority of the cases it is not sufficient to use any ordinary house, but we require a properly arranged sanatorium which must possess large rooms with abundance of light and air, with windows from the ceiling to the ground, through which the patients' beds can be moved on the adjacent balconies or terraces; the patients who cannot walk must lie there from morning to night, and many with advantage also, with proper shelter, during the night in fairly good weather. The rooms for meals and games must likewise be large and airy. Pavilions of moderate size, of one or two storeys only, are preferable to large blocks having two or three storeys. A pavilion for isolation of infectious cases is a necessity, and a well-arranged operating room is likewise indispensable, although in most cases, if taken early the necessity of operations can be avoided. Boys and girls ought to be in separate pavilions, when

(a) Abstract of Paper read before the British Congress on Tuberculosis, July, 1901.

older than five years, but may be in the same rooms up to that age.

There ought to be on the sea-shore sheds open on two sides, with rotatory arrangement, for shelter against wind and rain, and to some degree also against too fierce a sun. These shelters are especially necessary and must be numerous, if the balconies for lying out are inadequate, or too far away from the actual shore. To these shelters the little patients who cannot walk must be carried on comfortable kinds of bed-stretchers, and remain there during the whole day.

There must be good arrangements for bathing in the open sea and for tepid sea-water baths, to be used in winter as well as in summer. The resident medical officer must prescribe the diet for every single case, as also the nature and amount of walking and playing, and of Swedish or other gymnastic manipulations, particularly for spine or joint cases.

The beneficial effect of sea-side sanatoria can be greatly increased by providing each sanatorium with a *hospital or sanatorium boat*, arranged for the accommodation of the sick children, on which, in suitable weather, the invalids can be taken out to the open sea for shorter or longer periods of the day, since it is indisputable that the air on the high sea itself has a more powerful effect on the organism than that on the shore.

The duration of the stay of patients at the sanatorium ought not to be fixed by fast rules, but must depend on the nature of the case, and be left entirely to the judgment of the medical attendant. It may vary from a few weeks to a few years. To limit it to two or three months by the rules of the institution is absolutely wrong. If the patients are admitted at the beginning of the disease or at the first signs of the threatening, a short term will mostly suffice, while advanced cases of hip-joint disease or Pott's disease may require years, and ought not to be discharged before the cure is as complete as the circumstances admit.

Another mistake which is made at many sanatoria is the restriction of the treatment to the warmer months of the year. Although the weather at the northern sea resorts is not always agreeable during winter and spring, the patients at seaside sanatoria are under infinitely better influences than in their homes, or even in ordinary hospitals or infirmaries in crowded towns. The patients sent home during winter lose there often more than they had gained at the sanatorium during summer.

The number of children who require sanatorium treatment at the seaside is very large, and the number of beds available for them in England is very small. There are perhaps 300 beds in the seaside sanatoria of England, while 5,000 would certainly not be too many. Every hospital for sick children ought to have a seaside branch. It is almost incredible that there should be this strange defect in the hospital accommodation of England, especially when we reflect that the whole of the United Kingdom has such splendid sea-coasts, and when we further consider that England was the first country to awake to the great importance of this matter by establishing, on the suggestion of Dr. Lettsom and Dr. Latham, the General Sea-bathing Infirmary at Margate in 1791. The next country to move was Italy, which half a century later founded a sanatorium at Viareggio (1841); and France followed in 1847 by the sanatorium at Cette. While France has made great progress and deserves the highest praise for her enlightened philanthropy, England has remained almost stationary in this matter. The town of Paris alone maintains in its sanatoria at Berck-sur-Mer about 1,034 beds for scrofulous and rachitic children all the year round, and has also many beds

in several other seaside sanatoria on the French coasts. At Berck-sur-Mer, in addition, the benevolent Rothschild family gives perfectly gratuitous treatment to 100 children in the beautiful Hôpital Rothschild likewise, summer and winter. France has numerous other seaside sanatoria along her different coasts, mostly under the direction of the Assistance Maritime des Enfants Scrofuloux et Rhachitiques and l'Œuvre des Hôpitaux Marins. Independently of these seaside sanatoria France possesses, as already mentioned, the admirable inland sanatoria for tuberculous children at Ormesson and Villiers-sur-Marne (Œuvre d'Ormesson).

How is it that England, with its wonderful sea-coasts, and with its many excellent institutions for the sick, erected and maintained by private gifts, neglects this important matter? We cannot think otherwise than that the crying need for help and the possibility of bringing this help, are unknown to the philanthropists of this country, men as well as women. If they were aware of the great sufferings which the poor children affected with Pott's disease of the spine, with hip-joint disease, with caries of bones, or with tuberculous inflammation of joints, undergo in their wretched homes, and how large a proportion of them become consumptive later on, or cripples for life, or die after protracted misery; and if they knew, at the same time, that the majority of them can be cured entirely, and that many of the others can be restored to such a condition that they can earn their bread and can enjoy life, provided they are sent early enough to seaside sanatoria, many philanthropic persons would surely assist in supplying means to found numerous such establishments. It may be difficult to obtain all the means required by private benevolence, but the subject urgently demands also the attention of public bodies, such as the county councils and the Poor-law organisations. Associations like the trade unions ought likewise to feel the obligation to contribute their share towards the cure of the sick children of their members. The subject is so important and so large that I venture to suggest that an "*Association for the Erection of Seaside Sanatoria*" should be formed, as a sub-division of the *National Association for the Prevention of Consumption and other Forms of Tuberculosis*.

## MEDICAL EXPERIENCES IN SOUTH AFRICA. (a)

By JAMES B. COLEMAN, M.D., F.R.C.P.I.,

Physician to the Richmond, Whitworth, and Hardwicke Hospitals Dublin; and to the National Hospital for Consumption for Ireland; late Physician to the Irish Hospital, South Africa, 1900.

It is now a matter of history that when the Boer Republics declared war in October, 1899, the forces which we were able to oppose to them were utterly inadequate. The *personnel and matériel* of the Royal Army Medical Corps were exhausted when two army corps were provided for, and the help of civil surgeons and private hospitals had to be invoked to supply medical aid for the additional forces which were put in the field. Accordingly the Irish hospital was equipped and sent to South Africa at the beginning of February, 1900, through the generosity and patriotism of Lord Iveagh. Its staff consisted of Sir William Thomson, surgeon-in-chief; Dr. George Stoker, and Dr. Alfred Friel, surgeons; whilst I had the honour of being physician. We had six dressers, including Dr. Counihan and Dr. Pounden, with Messrs. M'Dwaine, Stewart, Edwards, and Thomson, and between orderlies, drivers, servants, and artificers, our company numbered about seventy. When we were going to South Africa the War Office would not consent to nursing sisters accompanying us,

(a) Read in the Royal Academy of Medicine in Ireland, May 17th, 1901.

but at a later period Lord Iveagh sent out Miss MacDonnell, matron of the Richmond, Whitworth, and Hardwicke Hospitals, and Miss Walker, sister in charge of the Whitworth Hospital, and their services can only be described as invaluable.

We arrived in Capetown at the end of February, and were at once sent to Naauwpoort, in the extreme north of Cape Colony. Here we received orders not to set up our hospital, but to be ready to proceed to Bloemfontein when the railway line was repaired.

#### NO. 6 GENERAL HOSPITAL.

Whilst the Irish Hospital was delayed at Naauwpoort awaiting the opening of the line to Bloemfontein in March, I volunteered to do duty at No. 6 General Hospital, which was stationed at Naauwpoort, and was given charge of seven marquees, containing forty-two enteric cases. The hospital had about 700 beds, and I was astonished at the completeness of its equipment, situated as it was on the veldt, 500 or 600 miles from Capetown. At that time about a third of the cases in hospital were enterics. They were all lodged in marquees, there was no overcrowding, and they all had comfortable beds. There was no lack of medical comforts, but additional nurses and trained orderlies would have been desirable, especially for night duty. The medical staff of the hospital consisted of Lieut.-Col. Somerville Large and four other R.A.M.C. officers, who were occupied with the work of administration, and sixteen civil surgeons, who attended to the treatment of the patients. In such a large hospital two senior medical officers would have been usefully employed as consulting physician and surgeon respectively. There were no facilities for bacteriological and pathological work, which was often necessary for accuracy of diagnosis and as a guide to treatment.

#### AT BLOEMFONTEIN.

The Irish Hospital opened at Bloemfontein on April 13th, 1900, our camp being pitched on sloping ground to the north of the town, at the foot of a large flat-topped kopje. We had accommodation for 100 patients in large, square tortoise tents, and from the start it was practically a fever hospital. The patients were very comfortable. On admission they were washed, supplied with pyjamas or night-shirts, and put into spring beds. They had everything that was necessary, except a sufficient supply of fresh milk, and for the latter condensed milk made a fairly good substitute. At first the nursing was done by our own orderlies, who displayed great devotion in the discharge of their arduous and often unpleasant duties; but subsequently we had trained nurses, and their advent was a godsend. Our patients at Bloemfontein were under favourable conditions, and in 150 cases of enteric in our hospital there had been nineteen deaths—a mortality of 12.6 per cent.

#### FROM BLOEMFONTEIN TO PRETORIA.

In May I accompanied the mobile section of our hospital in the march to Pretoria, Sir William Thomson being in charge. We were attached to the 11th Division, the efficient and courteous P.M.O. of which was Surgeon-Colonel Magill, of the Coldstream Guards. We had ten ambulance waggons, and our equipment was reduced to the minimum weight. We carried tents for fifty patients, and mattresses or stretchers for the same number. It might be imagined that on the march with a large army through the enemy's country the number of wounded would predominate over the sick, but the reverse was the case. Every day on arriving in camp we took cases of enteric into hospital, and when we entered Johannesburg we had sixty-nine patients, of whom two-thirds had enteric. Many of those cases had been carried in our ambulance waggons day after day on the march, and they suffered very great hardships, but there was no help for it, as it was impossible to leave them anywhere *en route*. Fortunately we had no death on the march, but I fear some of those patients must have died subsequently in the Johannesburg Hospital, where we left them, notwithstanding the good treatment they received in that excellent institution.

#### AT PRETORIA.

The Irish Hospital was under shell fire on June 4th outside Pretoria, and next day we entered the town.

On the 10th we had 105 patients, including sixty cases of enteric. We accommodated them in marquees and square bell-tents on the veldt near the racecourse, but the patients were overcrowded, and nearly half of them were lying on the ground, whilst, to add to their discomfort, the weather was cold and wet. In fact, the state of our hospital for about ten days after entering Pretoria was very unsuitable for the treatment of grave medical cases, and it was impossible to treat the enteric patients properly. But this state of things did not continue, for Sir William Thomson applied to the military authorities for the Palace of Justice for use as a hospital, and they not only consented but allowed the building to be fitted up and furnished luxuriously for the reception of 500 patients. In this onerous undertaking invaluable assistance was given by the Hon. Rupert Guinness, Mr. Murray Guthrie, M.P., and Mr. Leigh Wood. On June 19th we transferred our patients to this building, equipped as it now was with electric light, hot and cold baths, and good beds. The rest of our staff arrived from Bloemfontein at the beginning of July, and the P.M.O. supplied additional nursing sisters and orderlies. A high standard of excellence was attained in the management of the Irish Hospital in the Palace of Justice, and it is no exaggeration to say that the patients were as well off as they would be in many a first-class civil hospital at home. We remained in the Palace of Justice in Pretoria until we left for home last October.

#### ENTERIC FEVER.

Of the medical cases treated in the Irish Hospital, first in importance comes enteric fever, which constituted a terrible plague during the campaign. At the end of June, 1900, Lord Roberts informed me that there had been 6,500 cases of the disease at Bloemfontein alone, with 1,800 deaths. At the same place two general hospitals had nearly 3,000 cases at one time, and everywhere at the seat of war the same scourge afflicted our troops.

In our hospital register there are entered 672 cases of enteric, but I think the number treated was considerably in excess of that figure, for in many instances the diagnosis in our register was taken from the admission forms, and was not afterwards corrected. For instance, many cases were sent in as "simple continued fever" which were really enteric, but the former diagnosis appears in our returns.

I had 260 cases of enteric under my care, and through the courtesy of my colleagues I saw many of their cases. In general, the type of the disease did not differ from what we see at home. The diagnosis in doubtful cases was confirmed by a positive Widal reaction. In Bloemfontein I used the dead typhoid bacilli for the serum diagnosis, and I found they "clumped" satisfactorily with enteric serum. In Pretoria I had the use of the Staats Laboratorium, which was carried on under the able direction of Dr. Schmitz Dumont. Here I started fresh broth-cultures of typhoid bacilli, which I renewed from time to time, and I classed no doubtful cases as enteric in the absence of a positive serum reaction.

The temperature in our enteric cases calls for a few remarks. It was very high and very irregular. Twenty per cent. of my cases had a temperature over 105° F., and two cases over 106.5°. Late in the disease there was extreme intermittence, so that malaria had been wrongly diagnosed.

Enteric spots were present in 85 per cent. of the cases, and a transient erythematous rash in 10 per cent. Diarrhoea, on the other hand, was not troublesome in more than 20 per cent. of the cases.

Intestinal hæmorrhage occurred in 9 per cent. of the patients. The spleen was enlarged and the abdomen distended in nearly every case. Delirium was frequent. Lung complications were common, particularly bronchitis (18 per cent.), pleurisy (3 per cent.), pneumonia (2 per cent.), and œdema of the lungs. In two cases I saw Cheyne-Stokes' respiration.

Peritonitis and perforation occurred in less than 1 per cent. of the cases and thrombosis in 6 per cent.

The less frequent complications included epistaxis, meteorism, otorrhœa, neuritis, laryngitis, tonsillitis, parotitis, orchitis, retention or incontinence of urine, albuminuria, hæmoglobinuria, cystitis, urticaria, boils, mania, syncope, and hyperpyrexia.

Relapse or recrudescence was noted in about every fifth case.

As to the mortality in enteric, we had seventy-nine deaths in 672 cases, being a death-rate of 11·7 per cent. This was much lower than the general enteric mortality, but I make no invidious comparisons, as the conditions under which cases were treated were never alike. Eight of our cases died within forty-eight hours of admission to hospital, and four more within seventy-two hours. For a month after the occupation of Pretoria the condition of the Irish Hospital as regards equipment, &c., was superior to other hospitals near the capital of the Transvaal, and for this reason we were sent an undue proportion of very severe cases. For instance, on June 20th we received a sick convoy of thirty cases of enteric, which were sent from a field hospital about twelve miles east of Pretoria. Those cases were selected as the most severe of 120 cases in the field hospital, and they were sent to us as we had greater facilities for treating them. I regret to say that nine of these patients died, some of them being moribund on admission.

The most frequent cause of death was heart failure, and this occurred both early and late in the disease. Many of the fatal cases presented the picture of a severe toxæmia, and in such cases a pulse rate over 120 was always an ill omen. Among the fatal cases bronchitis and œdema of the lungs were very common, pneumonia was present in about 4 per cent., and perforation in 6 per cent. In one case cardiac syncope occurred in convalescence.

Post-mortem examinations were made in most of the fatal cases, and the usual enteric lesions were found.

The treatment adopted was expectant. For heart failure, stimulants and strychnine; for diarrhœa, restriction of the quantity of milk was usually all that was called for; for hæmorrhage, opium and turpentine mixture; for pyrexia, sponging or cold compresses, and occasionally cold baths. Wherever possible the use of the bed-pan was insisted on, and patients were not allowed to leave their beds for any purpose. During convalescence I endeavoured to increase the amount of the patients' diet as rapidly as possible, each case being treated on its merits, and the general condition of the patient being considered in addition to the one symptom of temperature.

Many of the troops were subjected to anti-enteric inoculation, and the value of the process has been much discussed. Whilst it cannot be described as an unqualified success, I believe it has been of use both as a preventive and in modifying the attacks of the disease.

Out of some sixty men of the staff of the Irish hospital who had been inoculated six contracted enteric and one died. About 12 per cent. of all our enteric patients had been inoculated, and in the majority of these cases the attacks were mild and of short duration. Among the inoculated cases the death-rate was 6·2 per cent., as contrasted with 12·5 per cent. in the uninoculated.

	Cases.	Deaths.	Mortality per cent.
Inoculated .....	80	5	6·2
Uninoculated .....	592	74	12·5
Total.....	672	79	18·7

Too much should not be expected from inoculation when we consider that enteric may occur more than once in the same individual, and we cannot expect inoculation to produce stronger immunity than an attack of the disease confers. We had several patients who had had enteric before, in India or elsewhere.

I have already remarked that many cases of enteric were sent to our hospital with the diagnosis of "S.C.F." (simple continued fever). I quite satisfied myself that those cases were enteric. In many instances they presented the clinical symptoms of enteric, and autopsies were performed on fatal cases, which

showed typical enteric lesions in the intestines. Other cases, though very mild on admission, had undoubted enteric relapses; whilst in others the history was characteristic. Finally, numerous cases which I examined gave a positive Widal reaction.

I believe that ambulatory enteric was common, but I do not contend that every patient with ill-defined febrile symptoms had enteric. I allowed the diagnosis of simple continued fever to stand in some cases, and influenza or febricula accounted for others.

The exaggerated intermittent temperature which was present towards the termination of an attack of enteric occasionally led to the mistaken diagnosis of malaria or "typho-malaria." The effect of large doses of quinine in reducing such temperatures was adduced in favour of their being of malarial origin, but the temperature fell also in the absence of quinine. Further, I examined the blood of such cases for the plasmodium malarie always with a negative result, whilst the same blood gave a positive Widal reaction.

#### OTHER MEDICAL CASES.

Medical cases other than enteric do not call for much comment. Dysentery was common, but the disease assumed a mild type, and the mortality was less than 1 per cent. I failed to find the amœba coli in the stools, and in no case did I see an abscess in the liver. The catarrhal form of the disease prevailed. For treatment, rest, milk diet, and sulphate of magnesia were efficacious, whilst the administration of ipecacuanha was disappointing. The worst cases of dysentery which I saw, including two fatal cases, were chronic cases of the disease which had been originally contracted in India.

Diarrhœa was very prevalent. Few men escaped a severe attack within a short time after landing in South Africa, and a certain amount of immunity resulted. The complaint was commonly known as "modders," from its supposed origin in drinking the Modder (a) river water. In some cases symptoms of severe enteritis or of gastro-enteritis were present.

A number of patients suffering from catarrhal jaundice were admitted to hospital about the time of the occupation of Pretoria.

Comparatively few patients were admitted to the Irish Hospital with malaria. Basing the diagnosis on the presence of the plasmodium in the blood, I came across no case in which malaria had been contracted in the Orange River Colony or in the Transvaal south of, or in, Pretoria. Most of the patients admitted for malaria had the disease previously in India or in Egypt, or in Rhodesia, but in some instances it had been acquired in the northern or eastern districts of the Transvaal. Simple tertian ague was invariably the form of the disease in the patients examined by me.

Rheumatic fever was of frequent occurrence, complications being few. Some cases were much prolonged.

Of pulmonary complaints the most serious was acute croupous pneumonia, whilst bronchitis and pleurisy were also prevalent.

Acute or subacute Bright's disease was not of uncommon occurrence, and a few patients were admitted with Bilharzia disease (endemic hæmaturia).

I saw many cases of "irritable heart" and tachycardia, and of the rarer diseases I may mention Addison's disease and alopecia universalis. One case of diphtheria occurred in our wards in Pretoria.

Before concluding I would wish to emphasise the fact that the number of medical cases in the hospitals in South Africa was vastly in excess of the surgical cases, and the corollary is that physicians were more needed than surgeons. In the Irish Hospital we treated 2,743 patients, of whom more than five-sixths were medical. Contrast our 672 cases of enteric with 114 cases of bullet wounds. In Bloemfontein in the large general hospitals, the enteric patients outnumbered the wounded in the proportion of twenty to one. Looking at the official lists of casualties, how often do we not see the statement at the top of a long list of deaths, "Died of enteric unless otherwise stated"?

Consulting physicians would have been of incalculable service in all the large hospital centres at the seat of

(a) Muddy.



war, and it is to be hoped that if, unhappily, the occasion arises again the sick will have the benefit of the services of a sufficient number of such physicians.

I have to express my thanks to my most efficient clinical clerks, Messrs. Percy Stewart and John McIlwaine, to whom I am indebted for notes of my cases.

## Clinical Lectures.

### THE VOMITING OF PREGNANCY.

By Prof. C. CRISTEANU, M.D.,

Professor of Gynecology in the University of Bucharest.

[SPECIALLY TRANSLATED FOR THE MEDICAL PRESS AND CIRCULAR.]

GESTATION, which is one of the most important functions of the human organism, can present, during its normal course, a series of complications, some of which are benign, while others have a baneful effect on the mother and the child, placing sometimes the lives of both in great jeopardy by the violence of the morbid manifestations. Among these numerous complications, I beg leave to insist specially on *vomiting*. This accident or complication can be met with very frequently during gestation, presenting all the varieties, from the slightest sensation of nausea to the most grave forms, where the patient is unable to support any solid food or liquid. The continued denutrition and loss of strength resulting from this complete inanition constitute an immediate danger, not only for the existence of the fœtus, but especially for that of the mother.

Authors have divided the vomiting into—slight, moderate, and grave, and this division suits all clinical purposes. The prognosis is difficult to determine, and the symptomatic treatment being uncertain, we are frequently obliged to provoke abortion to save the mother, and even then we are not always sure to attain our end, as I will show you further on.

The epoch of the appearance of the vomiting is very variable; it is seen generally in primipara, that is to say, during only one pregnancy, the subsequent pregnancies running their course without complications. It also happens, and frequently, that it occurs regularly at each pregnancy, placing the woman's life in danger.

In the large majority of the cases the vomiting appears in the half of the first month, and may continue during the whole period, but it generally ceases at the end of four months and a half. The causes are variable, and not well understood. Some authors attribute it to metritis of the cervix, others to uterine deviation, to gastric ulcer, cancer, tuberculosis, tumours of the neighbourhood, worms, albuminuria, and even to varicose veins of the legs.

Auvard asserts that where no apparent cause can be detected, symptoms should be attributed to a modification of the blood produced by the retention of toxic products. M. Pinard supposes intoxication resulting from bad function of the liver, or perhaps by a toxine secreted under the influence of pregnancy, and designates this state under the name of auto-intoxication. Kalténbach believes that he has found the cause in hysteria, yet cases are not wanting where it was impossible to discover any stigmata of hysteria. For me, I consider that hitherto the true cause has been ignored, but on this I believe the following cases may be able to throw some light.

Ten years ago I attended a lady of my family who presented the classical symptoms of incoercible vomiting. From the first month of her pregnancy

the patient was seized with nausea and vomiting, which increased rapidly in intensity, becoming almost incoercible after the second month. She vomited at every moment, even without taking anything solid or liquid, and was reduced to a state that, if her health had allowed it, abortion would have been provoked. The temperature rose slightly in the evening, and the emaciation was so great that she could not leave her bed. The urine secreted in twenty-four hours did not amount to more than seven ounces, very concentrated, containing abundant salts. All kinds of treatment were employed, without result. The vomiting ceased spontaneously in the fourth month, the appetite returned, but the patient presented an irresistible tendency to sleep after dinner; she fell off immediately wherever she was, into a deep sleep, which lasted all night. At full term she was confined, and both child and mother did well afterwards. What appeared to me to be extremely interesting in the above case were the antecedents of the family. The father had had several attacks of gout, and finally succumbed to an attack of angina pectoris. The mother had also the gouty diathesis. A sister died from congenital stenosis of the pulmonary artery. A brother suffered from articular rheumatism, while in the collateral branches hemiplegia, chronic rheumatism, biliary calculi could be traced.

This single case gave me light as to the relations which seemed to exist between heredity and the vomiting. All the family presented the same predispositions, the same characteristics forming the classical manifestations of arthritism, or rather herpism (Lancereaux). Consequently I was obliged to admit a *close correlation* between the incoercible vomitings and the herpeticism inherited from the family.

Lancereaux describes at great length in his clinical lectures the brusque apparition of symptoms and manifestations which are under the influence of the same cause: *herpeticism*. Gestation is one of these causes; it modifies profoundly the organism of the woman, and by that awakens the arthritic or herpetic diathesis, diminishing on the one hand the dissimilation of the products of combustion, retarding their elimination, with the consequence that toxic substances are accumulated in the organism. The necessity for the organism to eliminate at any price these products, to compensate these toxic substances by the gastric and buccal mucous membranes, leads as a natural consequence to irritation of these membranes, which react in their turn and produce the nausea and the vomiting especially in the morning, sialorrhœa, especially in the night and in the morning, benign manifestations sometimes, and at others incoercible, probably caused by the *local elimination* of the products of incomplete combustion. It may be asked why all pregnant women do not suffer from vomiting. First, because those of a herpetic or arthritic predisposition are especially predisposed to it, and, secondly, the same question might be asked under other conditions; why, for instance, all the patients who have a high temperature have not delirium? A predisposition is necessary, and this predisposition reacts according to each individual, and according to conditions which differ totally for each individual. Some present manifestations of the skin, others of varicose veins, others of hæmorrhoids, others of vomiting, ptialism, hysteria, mania, &c. These manifestations can vary according to conditions, but the cause is always the same, that is to say, *the herpeticism of Lancereaux*.

I will give briefly two or three cases which confirm my opinion:—A woman, æt. 28, entered the hospital for incoercible vomiting. She was two months pregnant. The vomiting and ptialism were

very abundant. *Traces of urea* were found in the saliva. I instituted the following treatment:—Mixture of chloroform, water, cocaine, and twenty drops of tincture of belladonna, gargles with Vichy water, warm baths, friction of the skin with aromatised alcohol, and *one drachm of carbonate of lithia* in a mixture given internally each day. Seven days afterwards the vomiting ceased and the ptyalism also. After ten days she left the hospital. A year subsequently she returned, two months pregnant, with the same symptoms; but being in a very prostrate state she was unable to follow the medical treatment. Curettage was practised, and two days afterwards the vomiting ceased, while the urine, which had come down to 500 grammes, went up to 1.500. On the tenth day the vomiting returned with the same intensity. The urine fell to 600 grammes and the ptyalism reappeared. The woman refused to remain longer in the hospital. It was evident that the vomiting was produced by another cause than that of gestation, as it should have completely ceased after gestation; and that cause was arthritism or herpetism. A third and fourth case entirely similar to the preceding were treated medically as indicated, and fifteen days after the patients left the hospital completely cured.

## HYDATID CYST OF THE LIVER,

By Dr. D. A. MORALAS PEREZ,

Professor of the Faculty of Medicine, Barcelona.

[SPECIALLY TRANSLATED FOR THE MEDICAL PRESS AND CIRCULAR.]

In the beginning of February last, Joaquina M., *æt.* 30, a native of Alcira, Valencia, spinster, a dressmaker, and for some years resident in Barcelona. The patient was thin, nervous, and had a peculiarly sad expression of face, which was heightened by an icteric tinge of skin and conjunctivæ.

There was no history of any family complaint which would account for the sickness. When the patient was twenty years old she had an attack of typhoid, in which she nearly lost her life, but since that attack she has enjoyed good health. Three years ago she felt a pain now and then in the right side, under the free ribs. At first the pains were of little moment, but they gradually became worse, until they became very violent and were attended with vomiting and purging, for which she took the mixture of Riverio (*a*).

The patient remained for some months under observation, during which time she applied belladonna ointment and appeared to suffer little pain; but she noticed that the right hypochondriac region became swollen. She had found that medicines did not free her from the disease, and she came to consult me on the necessity of having an operation performed.

Examination of the right hypochondriac region revealed a swelling which went from the right side to the middle line of the abdomen. The ribs were pushed forward, upwards, and outwards from the eleventh to the eighth. There was no clear evidence of fluctuation, but an obscure sense of it was felt, which appeared characteristic of sarcoma. It was plainly a solid mass. The skin was tense, limp, and almost translucent from the abuse of ointments and cataplasms.

From the examination I concluded that there was an hydatid cyst of the liver and sarcoma. From the very first I felt inclined to the diagnosis of an hydatid cyst.

After much hesitation the patient consented to an operation being performed, and was admitted to the hospital.

(a) The mixture of Riverio (*Dicc. de Med.*) is an effervescent mixture of bicarbonate of potassium and citric acid.

After she had had a saline purge and some baths the operation was commenced by cutting with a thermo-cautery, for fifteen centimetres, parallel to the border of the ribs, and through the most prominent part of the tumour. All the tissues were cut through, the right rectus abdominalis muscle was incised, and the epigastric artery was ligatured.

When the bleeding was completely stopped the peritoneum was caught up by two forceps, and a hole cut in it, which was enlarged with a pair of scissors this served as a guide to the left index finger, by which the convex surface of the liver was readily made out. The peritoneum was sewn to the cutaneous surface, and the wound closed with gauze and covered with surgical wool. The temperature remained normal, and the pulse did not exceed 72.

During the night she had severe pain in the site of operation, and it became necessary to give her an injection of morphia and atropine which had previously been prescribed for her, should it be necessary; the hypodermic was well borne and gave her a night of tranquil sleep.

On the third day she was given some food; the first day she had none, and the second day she was confined to milk alone.

On the sixth day, I being ill, Dr. Jaumandrew on examining the wound found that the surface of the liver had become adherent to the edges of the wound and that the abdominal opening did not communicate with the peritoneal cavity.

As I expected, the hydatid cyst was retro-hepatic and deeply placed in the tissue of the gland. I ordered a special thermo-cautery bistoury with a blade nine centimetres long. On March 14th, the patient being chloroformed, I proceeded with the second operation by plunging the incandescent bistoury six centimetres into the liver, and no fluid escaped. I again decided to re-introduce the bistoury, and having cleaned the blade of the stains of the cauterisation, introduced it. No fluid came, but there was distinctly a sensation felt of having entered a cavity. Withdrawing the blade I felt that the diagnosis was uncertain. Once more I introduced the knife, and at last opened the cyst from which a clear watery fluid was squirted out, wetting my assistants. Enlarging the incision two litres of fluid were drawn off, which on examination microscopically was seen to be hydatid fluid. A large drainage tube was inserted and kept in position with surgical gauze. The temperature remained normal.

In three days' time the gauze was saturated with bile, and the fæces were as if the patient had jaundice. This condition remained unchanged for some days.

On April 15th the patient was able to get out of bed, the wound having gradually closed; there was no discharge of bile from the fistula for some days, the fæces were coloured as in health, the swelling had gone, and the patient was well.

The case presents many features worthy of consideration. The patient had in her house a dog, which was a constant companion, and eat the residue of her meals. It is further of interest to note that one day when moving a machine she gave herself a severe blow on the right hypochondrium. The ætiology of hydatid cyst is well known; the germs of the *tænia* pass from the intestine and traverse the viscera, forming cysts in those that have been the seat of an injury.

In countries in which dogs live in the dwellings, as in Iceland, hydatid cysts are very common. The same effects follow in Abyssinia, where *tænia solium* is so very common as scarcely to be counted a disease, and the patients seek no other remedy than the indigenous one *brayera anthelmintica*, the use of which is handed down from prehistoric times.

In many experiments which I have performed for different purposes on dogs, I have found the *tania solium* in the intestines of the majority of them.

The liver seems to be the most subject to hydatid cysts, its anatomical relation to the duodenum, its vascularisation, and its structure favour the passage of germs, and its site and size favour its being injured by blows and so forth.

Statistics published by Herreon-Vegas and Daniel Cranwell, physicians, of Buenos Ayres, show that out of 952 hydatid cysts, 641 were situated in the liver, four in bones, and one in the breast.

In the same article (*Revue de Chirurgie*) the statistics of Neisser are quoted, which show 451 cases of hydatid cyst of the liver out of 983 cases observed.

The physicians of Buenos Ayres ascribe this spread of the disease to want of personal cleanliness in those affected, and they quote the case of the butchers in that city who kill so many animals for consumption with impunity, though observation shows that of horned cattle 40 per cent. contain the *echinococci*, and of pigs fully 60 per cent. The rapid increase of the disease in Buenos Ayres has alarmed the authorities in Argentina. During the year 1877 there was but one case reported in the city; in 1888 sixteen cases were admitted to hospital; and in the year 1898 there were 173. In Spain the cases appear to be getting more numerous than formerly.

I believe that in this country (Spain) it is highly probable that the *echinococci* pass their temporary stage in rabbits. These animals are very subject to be infected by intestinal parasites, and the rearing of the rabbit is now a considerable industry, especially in Cataluña. Some years ago Dr. Colt, of Pujot, exhibited pathological slides of the intestines of rabbits, full of the germs of *tania*.

In reference to the method of operation, I may say I have twice operated in the same way. It has the disadvantage of a large broad cicatrix, which cannot, however, equal the ever-present danger of an hepatic hydatid cyst.

Some surgeons complete the operation at one sitting, suturing the hepatic opening to the cutaneous surface; this method of operation I have not performed, and I prefer to complete the operation after an interval of a few days. I have also found it impossible to draw out, as some profess to do, the whole cyst in such cases. And many of the post-mortem operations recommended in books and journals I have found impossible of performance on the living.

I have no desire to discuss the many surgical proceedings enumerated in text-books on the subject, such as punctures, injections, electrolysis, and so forth, all of which have, in my hands, not been satisfactory.

Before concluding, I desire to say that if when the viscus is penetrated by the blade of the knife to its depth and no cavity is reached, the blade should be withdrawn and again plunged in, when, if the cyst is opened, the contents of it gush out as from a fountain. The blade should have a dull red colour, having been heated to a cherry-red colour and allowed to cool down. The knife may be introduced a second time into the cyst at a dull red heat to destroy the mother-membrane.

#### A Nurse Charged With Libel.

A NURSE called Clara Cooper is under remand at the Dawlish Police Court charged with writing and publishing certain scandalous and defamatory libels in respect of Dr. Charles Newton Lovely, of that town, by means of letters and post-cards.

## Clinical Records.

### PRINCE ALFRED HOSPITAL, MELBOURNE, AUSTRALIA.

#### Total Gastrectomy for Carcinoma of the Stomach.

By HENRY O'HARA, F.R.C.S.I.,

Senior Hon. Surgeon to the Prince Alfred Hospital, Melbourne.

SINCE Schlatter's celebrated case of complete removal of the stomach, I have watched with much interest the reports of other gastrectomies performed by Favre, Brookes, Brigham, Richardson, McDonald, and Boeckel. The results have been so encouraging that I determined to perform an operation on the first favourable case which presented itself.

Dr. Weigall, of Cheltenham, kindly sent a patient to me with a very marked history of cancer of the stomach. Rapid wasting epigastric pain and vomiting after taking any food, and a marked cachexia. On examination a hard moveable tumour, the size of a goose's egg, could be felt in the region of the stomach, and the vomited matter was alkaline. On consultation with my colleagues at the Alfred Hospital, it was decided to feed up the patient for a little while in the hope of getting him strong enough to stand the operation. The following notes and chart have been kindly supplied to me by Dr. Elvins, house surgeon to the hospital:—

R. P., *æt.* 50. Patient complains of vomiting his food after meals. About six months before admission he first noticed that he rejected his food. He did not vomit until about one or two hours after a meal. He says the food seemed to settle for a while, and then came back in a liquid form. He suffered a good deal of pain in the epigastrium, noticed himself swelling up a good deal after food, eating or drinking, never vomited any blood. Appetite always good, but could never retain anything. Has been steadily losing weight; lost two stone weight in six months.

On admission patient was in a very thin and emaciated condition; weight, 7 *st.* 4 *lb.*; height, 5 *ft.* 7 *in.* Complained of great pain in epigastrium. Above the region of the pylorus a large hard mass could be felt more or less distinctly. Stomach was greatly dilated; its outline could be easily mapped out. Appetite good, inclined to be voracious; bowels regular; heart and lungs showed no sign of disease; urine, 1,025 acid, no albumen, no sugar.

Patient was put on liquid diet; very small quantities at frequent intervals. Did not vomit much, but vomited matter was dark coloured, not unlike "coffee grounds," sour smelling, alkaline. Patient seemed to improve under treatment, vomiting almost entirely ceased, and he seemed to be able to digest fairly well the small quantities of liquid food. He gained four pounds in weight in three weeks. As patient's condition was much improved and as he was very anxious to have the operation performed, it was decided to explore. Accordingly, on January 1st, 1901, Mr. O'Hara opened the abdomen by a medium four inch incision and the mass was exposed. A large hard mass, apparently malignant in character, was found, involving the pylorus and extending along the greater curvature of the stomach, and its interior wall for about two-thirds of the distance between the pyloric and cardiac ends of the stomach. No enlarged glands could be discovered. Clamps were placed on the œsophagus, and above the duodenum, including the disease, and the whole mass excised. The large opening in the cardiac end of the stomach was partially closed by sutures through the mucous coat and a layer of Lembert's sutures outside, all hæmorrhage being checked by ligatures or torsion of vessels. A large size Allingham's decalcified bone bobbin was now inserted in the cardiac orifice, or, more properly speaking, the subdiaphragmatic portion of œsophagus, and fixed there with a purse-string suture, the cut end of the duodenum was then pulled over the other end of the bobbin and fixed in a like manner. The peritoneal surfaces being thus brought in apposition were fixed there by a double row of Lembert's sutures. A portion of the gastro-hepatic omentum was sewn over this anastomosis to make the union more secure. The

abdominal cavity was washed out with saline solution. The anæsthetic used was ether, and oxygen was given during the latter portion of the operation. The time taken to complete the whole operation was a few minutes less than one hour. About one quarter of an hour before the operation the stomach was washed out with boracic lotion.

*After treatment.*—The evening of the operation the patient's breathing became very laboured. Hypodermic injections of strychnine were ordered, m. v. of the liq. strychniæ every two hours, and oxygen inhalation every half hour. Breathing became much easier. Vomited dark brownish fluid several times. Temperature 98.4. Pulse 136.

On the 19th he was breathing much better. Complained of pain in the epigastrium. Had hypodermic injection of morphia gr. ʒ. No vomiting, but had retention of urine, for which catheter was passed; nutrient enema administered every four hours.

The bowels were well opened several times on the 21st, the pain was much easier, and he slept well.

Had the first food by the mouth since the operation on the 22nd—one teaspoonful of milk, brandy and water, or Brand's essence given every half hour. Nutrient enema stopped.

From this time onwards till his discharge, the patient continued to improve rapidly, and with the exception of an occasional small rise of temperature and pulse, he made an uninterrupted recovery. Sixteen days after the operation the wound, which had been covered with collodion, was exposed for the first time, and was found to have united by first intention; the stitches were then removed. The growth proved to be carcinoma. On February 6th he had bread and milk, and was put on No. II diet, i.e., nineteen days after operation was able to take ordinary solid food. On February 18th he was discharged, feeling very well.

Note by Dr. Weigall:—

The patient was seen about a week ago (July 22nd) six months after the operation, he had gained nearly two stone, and expressed himself as feeling very well, and able to take any kind of nourishment. To ensure a successful result for this operation, I consider the following points most important:—

1. The disease must be confined to the stomach, i.e., it must be inside the peritoneal lining of that organ, so that it can be completely removed without disturbing the important structures in the neighbourhood.

2. There must be a sufficient amount of cardiac end free from disease to complete the anastomosis with duodenum. There must be no dragging of the parts together, as the duodenum, if free from disease, can easily be loosened sufficiently to allow of the anastomosis without any tension.

If, then, carcinoma of the stomach is found to exist without being complicated with lymphatic deposits or other evidence of visceral metastases, and if emaciation the result of starvation and vomiting has not gone too far in reducing the patient's strength, I consider a total gastrectomy not only a justifiable operation, but one that gives the only chance of prolonging life under the conditions.

## Continental Notes

[FROM J. E. WOLFE, M.D., F.R.C.S. ED., LATE OF GLASGOW.]

VIENNA, September 13th, 1901.

### ON THE RESUSCITATION OF THE PARIS POST-GRADUATE MEDICAL SCHOOL.

I was about to write some notes on the scope of the Vienna clinics as a post-graduate school in the various departments of medical science, when I noticed in this week's issue of THE MEDICAL PRESS AND CIRCULAR (August 28th) a leading article on "The Parisian Medical School." This article claims my first attention

concerning which I venture to offer a few remarks. I am attached to the Paris Medical School by ties of deep gratitude. I was a post-graduate student under Nelaton, Trousseau, Velpeau, Claude Bernard, and Desmarres, by whose brilliant achievements in ophthalmic surgery I was attracted to that speciality. Being at that time the Paris correspondent of *The Lancet*, I came into friendly connection with these great authorities. If I have contributed anything to medical science I owe it chiefly to these great masters, who, by their example and practice, have shown us the manner and spirit in which scientific investigation should be conducted. That was the golden age of medicine, when science was cultivated purely and impartially—free of school cliquism and international jealousies, and Paris was the metropolis and centre towards which all eyes were directed, to read the last lecture of Trousseau, and the last experiment that issued from Claude Bernard's laboratory. Now we are told that, "during the past twenty years the French schools of medicine are being gradually deserted by foreign students, who now seek instruction in Vienna and Berlin." How is it? We may well ask why it is that this beautiful city with its unsurpassed clinical material, its unrivalled anatomical institution at Clamor, its bright hospital people, its beautiful language and moderate living, how is it that all these advantages should have been abandoned by foreigners?

It cannot be owing to the want of attraction of such great luminaries just mentioned, for Vienna, at that period, was represented by men of exceptional celebrity, one need only mention Hirtel, Rokitsansky, Skoda, Jaeger, Arlb, Hebra, Strücker, Billroth. Edinburgh, also, could at that period boast of an array of bright stars who illumined the medical horizon: Goodsir, Simpson, Syme, Christison, Miller, Bennet, Allison, Playfair—these were names to conjure with, to raise the prestige of a school. But then prophets do not live for ever, nor do medical celebrities; they train assistants who follow their example and methods, and their work is perpetuated. These assistants may even improve upon their teachers by bringing the subjects up to date. Thus the Vienna and Edinburgh schools, having grown in prosperity, added largely to the contingents of foreign students, and we might have expected not less of Paris, where the professorial chairs are filled up from the most successful—from the pick of agrégés, men who go through a course of thorough training for these important offices from the very commencement of their medical career.

The condition complained of must have been produced by a strange apathy and waste of rich material—like an "unweeded garden that grows to seed." It is well, as your editorial informs us, that the city authorities have taken up the question and are discussing means of establishing a post-graduate school upon a sound basis: "A municipal institute of practical medicine is to be established and supported at the expense of the city. Patients are to be drawn from all parts of French territory, the desire being to secure specimens of pathological states of rare occurrence," &c. The same, I presume, will be done for this municipal institution which Gambetta did for the Eye Clinique of Quinze-Vingts. There is every reason to expect that things will be devised on the most liberal scale

and most carefully organised to do credit to the municipality. I most cordially join the editor of THE MEDICAL PRESS AND CIRCULAR in wishing the scheme success. I may, however, take the liberty to offer one remark upon the closing sentence of the editorial, viz. :—

“The home of Pasteur should be an attraction to students, and our French *compères* are well advised in teaching Pasteur's theories and demonstrating his teaching in Paris, and not relegating the duty to German professors.”

There can be no doubt that Pasteur's teaching is admirable, although I am unable to follow him in all the statistics and deductions of his school. Of the medical practitioners who resort to foreign schools but few, however, wish to study Pasteur's theories; to the bulk of them Pasteur reads like Hegel or Spinoza. It is for the teaching of practical subjects that provision must be chiefly made.

## Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, September 14th, 1901.

### FACIAL BONES AND PARALYSIS.

SALOMONSON showed two cases of a longstanding paralysis of the face to prove the fallacy of Schauter's theory founded on experiment.

The first case was that of a female who had suffered from facial paralysis for twenty-seven years; the second, a male, who had been afflicted forty-eight years with the same thing. The bony structure of the cheek was in no way reduced or softened, but on the contrary, was full and firm, which is to be expected from the removal of the muscular pressure on its surface, which would reasonably retard the development of the bone.

### “PURGATOL,” A NEW LAXATIVE.

DR. WENHARDT JANOS introduced this new cathartic in a lecture to his class at the University Clinic, Budapest. It is a synthetic glucoside endowed with the natural properties of purgation. It is claimed for it that it is a drug the effects of which can be easily estimated; it is tasteless; passes through the stomach unchanged, and, therefore, does not disturb the digestive function. It is given in doses of from 0.5 to 1.0 gramme. It produces no griping, tenesmus, &c., and is useful in the purely functional constipation of neurasthenia.

### ARSONVALISATION.

Eulenburg has been experimenting with high tension intermittent currents, and finds that there is a steady increase in the blood pressure when measured with a large solenoid and Basch's sphygmo manometer. The previous experiments on animals with a cannula in the carotid connected with a mercurial manometer gave no particular change. Along with the high arterial tension the depth and frequency of the respirations are increased, the absorption of nitrogenous products augmented, and the elimination of carbohydrates doubled. In the case of local arsonvalisation there is a decided reduction in the perception of cold, heat, and pressure, not so much that of pain in the particular area acted on. Later, however, there is hyperæsthesia for cold and heat, often associated with hyperalgesia, which can be relieved by local analgesics, anæsthetics, or anti-prurigenous drugs. This form of electric application

has been found useful in some faciei and lichen ruber. French authors speak highly of it in functional neurosis and morbid assimilation.

### SEPTIC ENDOCARDITIS.

Septic endocarditis may be acute or chronic in its course, or, as in some cases, it may take both courses. In addition to the purulent cocci, or staphylo- or strepto-cocci, the pneumo-cocci, or more rarely the gonno-cocci, may be the exciting cause.

According to Lenhartz, twelve cases of septic endocarditis occurred in old cardiac lesions, five times in the puerperal condition, four times at the onset of gonorrhœa, and seven times from injury to the urinary tract after the passing of a catheter, bougie, or other instrument.

The bacteriological examination gave staphylo-cocci eight times, pneumo-cocci nine times, strepto-cocci ten times, and one only contained gonococci.

The chronic form of the disease is slow and insidious, seldom occurring with rigors. The usual form is a feeling of lassitude, weariness, and exhaustion, with aching in the joints; sometimes there is great pain in the neighbourhood of the joints and sponges. These dangerous symptoms gradually increase in severity, with the appearance of a cardiac murmur and great increase in the size of the spleen. There is nothing pathognomonic in the temperature as many have no rigors whatever, while in others it may be erratic, with an intermitting or remitting curve. The prognosis is always grave, as is shown by the fact that out of thirty-eight cases he had only four recoveries.

### SPECIFIC BLOOD CHANGES AFTER URINE INJECTION.

The serum from animals treated with the urine of men and goats acquires an agglutinating property. This phenomenon is most marked in man. The blood serum has no power of this nature when acted on with the urine of a horse, having neither hæmolytic nor agglutinative property. “Precipitine” and “anti-complemente” are not to be found in the serum of the animal that has been inoculated with the urine of a goat. The case is very different when the serum contains the active principle of the guinea-pig, or when acted on by the inactive serum of the goat, where great quantities of “anti-complemente” and “precipitine” are formed, while “hæmolysine” is absent, but agglutinine is sometimes present.

### TREATMENT OF MOTOR APHASIA.

The therapy of cerebral aphasia, or aphasia after cerebral disturbance, is more hopeful than is generally believed if a systematic course of treatment be followed. Careful tuition, according to Vidal, should be carried out on truly physiological lines, which in his hands has given wonderful results, when the case is purely motor aphasia; but the case is very different in prognosis when combined with amnetic aphasia. Treatment under the latter conditions is very unsatisfactory and imperfect in its results.

### CHOLEDOCHOTOMY.

To obviate the operation of choledochotomy Rose proposed and carried into practice the sounding of the gall passage from the duodenum with a considerable amount of success. Again, Krug has demonstrated the practicability of passing the sound and removing concretions from the common duct. Krug thinks choledochotomy should never be performed where a calculus

simply blocks the passage, as this can easily be returned to the gall-bladder by the aid of the sound, thus proving the value of the simpler operation.

Where the stone is encapsuled this simple application will not succeed, and the case will consequently require the major operation of cholecystotomy.

#### CRYSTALLINE IMMUNISING PRODUCT.

The crystalline immunising substance which Buchner named "globulite" turns out to be a barium sulphate of albumen. The barium seems to have been present

Kühne peptone or other altered form of blood, in the serum.

## Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, September 14th, 1901.

IN the *Berliner Klinik*, H. 155, Dr. E. Felix has an article on

#### ADENOID VEGETATIONS.

This disease was first thoroughly described by W. Meyer in 1888. It occurs most frequently between the fifth and fifteenth year of life, but cases have been observed very early in life and also in old age. The frequency of the affection is very varied as regards locality and race. It is more common in the north than in the south.

Although one is generally inclined to consider hyperplasia of the tonsils to be the result of inflammation, this cannot always be proved. According to Fraenkel, adenoids are to be looked upon as an anomaly of growth, and nutrition. In the aetiology of the affection the infectious diseases—scarlatina, measles, diphtheria, and whooping-cough—play a part as predisposing factors. According to Zeim, suppuration in the neighbouring cavities also bring about adenoids. Another question that has disturbed authors during recent years, is that of the connection between hyperplasia and tuberculosis. This question has not yet been satisfactorily settled. From the histological standpoint Dansac has distinguished three forms, the scrofulous, the lymphadenitic, and the syphilitic. From the symptoms Curciller divides them into three groups, the respiratory, the auricular, and the mixed.

Digital examination leads to a correct diagnosis when the soft masses can be felt. Ozena is often present, which disappears on removal of the growths. Obstinate bronchial catarrh which resists all treatment is often associated with the condition. By swallowing the pus secreted, disturbances of nutrition are often caused.

The treatment is surgical, but supported by preparation of iodine, cod liver oil, sea-bathing, and hydrotherapeutics. The earlier the operation is undertaken the better. Tender age is no contra-indication. Even children at the breast thrive remarkably after successful operation. With bleeders one must be very careful, and it is better generally with such not to undertake surgical operations. If acute inflammation is present it is best to wait until it subsides. The best instrument for use is the one to which the surgeon is most accustomed. Many use the finger only, armed or not. The author

prefers Gottstein's ring knife to all others. As regards anæsthetic, cocaine may be used, and chloroform is not more dangerous than in other operations. The complication most to be feared is hæmorrhage in hæmophiles and in women who are menstruating. Hæmorrhage may come on immediately after the operation. Amongst unpleasant sequences of the operation may be mentioned tonsillar inflammation, mastoiditis, purulent middle ear inflammation, adeno-phlegmonous and retro-pharyngeal abscesses. Recurrence may take place even after complete radical extirpation.

#### SALOCHININE.

SALOCHININE, or saloquinine, is one of the esters of quinine, the quinine ester of salicylic acid. According to M. Overlach in the *Ch. f. innen Med.* saloquinine possesses the following advantages over quinine itself. It is first of all absolutely tasteless. It produces no disagreeable head symptoms, such as ringing in the ears, headache, or deafness. It exerts no irritating effect on the mucous surfaces either in large doses or after prolonged use. Two grammes of saloquinine are equivalent to one gramme of ordinary quinine. As an anti-neuralgic, the author places it in a front rank in sciatica as well as in other neuralgias. The doses must not be too small, however. In the case of adults he gives two grammes for a dose once or more times a day. In the case of sciatica he gives the two grammes towards evening. If the pain gets worse the third night he gives a second dose in the night. This dose does the work and the onward course is satisfactory. For typhoid he gives saloquinine in preference to other drugs, and gives two grammes just before the bath.

A further advantage of saloquinine is that it can be employed as a base for other acids than those generally employed for quinine. Two groups of salts are formed, the acid, and the neutral. The acid salts have such a horrible taste that they are useless, but the neutral salts, on the contrary, are quite tasteless and non-irritant, and they afford the practicability of using useful acids along with the quinine base. A very important combination is that with salicylic acid, and named, on account of its almost specific action in rheumatism, "rheumatine." It is a salicylate of saloquinine. The anti-rheumatic action of the combination is excellent. The rapid relief of cardiac pain is especially noticed. He places it above all other anti-rheumatic remedies. For the three first days of treatment he gave three grammes in one gramme doses. The fourth day a pause is made, and after that it is given in one gramme doses four times a day for four days. A welcome advantage of this drug is that it is absolutely tasteless; it is neither sour nor bitter nor sweet, and it does not disturb either digestion or the head. It is also useful in the gonorrhœal form of the disease, in neuritis, muscular pain from over-exertion or injury, and in the lancinating pains of tabes.

The *Deutsch. Med. Zeitung* contains an extract from a paper by Dr. Rose, of Strassburg, on

#### THE COURSE OF TUBERCULOUS PERITONITIS WITHOUT OPERATION.

The observation of such a case, and still more of a series of such cases, is at the present time one of such rarity as to make it extremely interesting. The chief result of the author's observations is to the effect that

a third of all cases of tuberculous peritonitis would recover without operation and much more frequently than has been assumed. The question as to whether laparotomy does most, or a conservation and wasting course, has not yet been decided, and will not be until the work of a large number of hospitals has been tabulated. Cases requiring operative treatment must be distinguished from such as do not. If the fever and swelling subside under conservative treatment, and the general condition and strength improve, the patient has been spared a serious, if not dangerous, unnecessary operation. But when there is a purulent exudation or a purulent cavity the patient's strength should not be allowed to run to waste before sending him to a surgeon. The difficulty here lies in that of an exact diagnosis, and the case is sometimes left until the operation is done in desperation. Without operation the patient dies; with operation he does generally, but now and then such a case can be rescued, especially when the exudation is encapsuled. There are also those cases in which the indications for laparotomy are occasionally intestinal stenoses, ileus, fistula, tuberculous tumours of the female pelvis or genital organs. It is different, however, in the dry fibrous with fibrous ascitic forms that form the main contingent of the cases recovering after laparotomy. According to all appearances these cases recover just as well without it.

The same journal has a reference to the

**SURGICAL TREATMENT OF ASCITES IN ATROPHIC CONTRACTION OF THE LIVER,**

by Dr. Kosciowski.

The first case was that of a drunken woman, *æt.* 45, who had been ill two years. Fourteen months ago she was operated on, when the liver was found to be contracted; it was small, nodular, and hidden under the ribs, and could only be felt with difficulty. There were no complications on the part of other organs. The omentum was stitched into the wound in such a way that it was in contact with both the peritoneum and the subcutaneous connective tissue. Recovery was undisturbed. On the eleventh day after operation paracentesis was performed, but was not repeated. Now there is a pronounced network of veins running to the cicatrix. Two months ago fluid collected again, but it was absorbed without puncture. The patient is now perfectly well and able to perform her domestic duties. The second case was that of a countryman of 40, who had been ill for fourteen years. Alcoholism was denied. At the operation performed in 1899 the liver was found to be enlarged and to reach to within an inch of the navel. On the sixteenth and twenty-first days after operation the abdomen was punctured on account of rapid return of fluid. The patient lived seven months after the operation without further puncture being required. A third case was that of a countryman of 45 who had been ill two years. There was enormous ascites. After removal of the fluid the abdomen rapidly refilled to the extent of a litre a day. At the operation the liver was found to be small, whilst the spleen was enlarged to three or four times the normal size. Even after the operation no improvement took place, so that the steadily recurring ascites had to be relieved once a week by abdominal paracentesis.

## The Operating Theatres.

### WEST LONDON HOSPITAL.

**TWO CASES OF NEPHRECTOMY.**—**MR. BIDWELL** operated on a man, *æt.* 29, who had previously been operated upon for the removal of a renal calculus. Three weeks previously he had been admitted into the hospital with considerable swelling and tenderness in right loin, and with some signs which pointed to a sub-phrenic abscess. There was some dullness and crepitation at the base of the right lung. The temperature was 103°, and there was redness and oedema just below the last rib. As the seat of the suppuration was not certain an incision was made in front below the costal arch. It was then found that the swelling was due to pyonephrosis, and on opening this a large quantity of pus escaped, and a calculus the size of a hazel nut was found blocking the opening of the ureter. A drainage tube was placed into the kidney and the rest of the wound closed. Progress was uninterrupted for the first week; the temperature being normal; when one morning he had a severe attack of hæmorrhage from the wound, the whole bed being soaked with blood. The wound was plugged by the house surgeon and the bleeding stopped, but he continued to pass a large amount of blood in the urine. From this date the temperature began to rise, going up to 103° and not going below 101°. He also had one or two slight attacks of bleeding when the plug was removed, but declined any further operation until the day before, when he had another and more severe attack of hæmorrhage. The ordinary incision was made in the lumbar region, and the kidney exposed. It was found to be very soft and friable, and in parts there were some foci of suppuration. It was removed after ligaturing the artery, veins, and the ureter separately. It was then found that the kidney had been surrounded by a very large blood clot, which was now breaking down, and was evidently septic. Several handfuls of this were removed from beneath the diaphragm and the wound irrigated. Two large drainage tubes were inserted and the rest of the wound closed.

It is satisfactory to state that this patient made a perfect and uninterrupted recovery.

**CASE 2.**—A man, *æt.* 40, who was admitted into the hospital having been knocked down and stamped on by a horse. There was a fracture of the tenth and eleventh ribs on left side. The abdomen was rigid and board-like, and did not move at all on respiration. The patient could not pass water, but on passing a catheter almost pure blood was drawn off. The patient was in great pain and was vomiting, and had a feeble, rapid pulse. The kidney was exposed by the usual incision, and on opening the transversalis fascia a large amount of blood was found surrounding the organ. The kidney was brought outside the wound, and on examination it was found that there was a deep rent in its posterior surface, extending into the pelvis, there were several smaller rents, from all of which there was free bleeding. Attempts were made to ligature the bleeding points in the kidney, but the parts were so friable that no ligature held. Very free hæmorrhage continued and was not controlled by plugging. The patient then became very faint, and the anaesthetist wished the operation concluded as soon as possible. The pedicle was therefore clamped and the kidney cut away. The pedicle

was then ligatured with strong silk, and before removing the clamp a ligature was applied to the renal artery. The clamp was then removed, and immediately there was a gush of blood showing that the ligature on the pedicle had slipped. Fortunately the renal artery had been secured previously so the bleeding was only venous. The vessels were picked up with some difficulty and tied. The wound was closed after uniting the muscles in two layers with silk sutures, and a small drain was left in the posterior part.

It is satisfactory to state that this patient also made a perfect recovery and had no further bleeding.

Mr. Bidwell remarked that the operation of nephrectomy was a very successful one, and was indicated in all cases of pyonephrosis; in the first case, however, the condition of the patient at the time of the first operation made it necessary to do as little as possible. He would not like to do such an operation as nephrectomy, which left so large a cavity and opened up lymph spaces so freely on a patient who was suffering from pyonephrosis accompanied by perinephritis. In such case the course followed was preferable, namely to drain the pyonephrosis first and then when the inflammation had subsided to remove the kidney if necessary. The accident which occurred after the first operation, namely, hæmorrhages, was a most unusual one, and but for the prompt plugging of the wound might have proved fatal. It is interesting to note that the plugging was followed by a large collection of blood in subphrenic space, and it was the suppuration of this blood clot which produced the high temperature. With regard to the traumatic case, Mr. Bidwell remarked that he would not feel inclined to remove an injured kidney unless the pelvis was extensively lacerated, since most extensive wounds in the kidney substance healed readily; when the laceration extended into the pelvis the vessels divided were so much larger that it was difficult to control the bleeding by plugging alone; in this case as the ligatures failed to hold, and the patient was getting faint, nephrectomy was decided on. In order to save time, the pedicle was ligatured *en masse*, but this was not his usual custom, since in nearly every other case of nephrectomy he had done he had ligatured the artery, vein, and ureter separately. Mr. Bidwell mentioned that he had carefully noted the effect of nephrectomy and the amount of urea secreted. Immediately after the operation the amount of urea was found to be increased, but on the second day it decreased in quantity and did not become normal till the end of a fortnight. He, therefore, recommended that patients should be kept on a low diet for the first fortnight after a nephrectomy.

THE practice of allowing unqualified persons to minister to the medical requirements of paupers and casuals is one which cannot be too strongly condemned. In a case recently investigated at Derby, it was elicited that an inmate of the Belmont Road Workhouse complained of feeling ill, and was given a pill by one of the male nurses, and died on the following morning without having been seen by the proper medical officer. If an inmate is ill enough to require medicine, he is ill enough to see the doctor, and nothing can justify the intervention of an unskilled official, even to the extent of giving an un-prescribed pill.

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## The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, SEPTEMBER 18, 1901.

### THE PSYCHOLOGY OF ASSASSINATION.

THE assassin—the executive apostle of anarchy—has again been busy among the most prominent, if not the most “truly great” ones of the earth. The selection of the latest victim of the levelling-down principle presents a new feature of most striking philosophical, as well as political and social, interest, inasmuch as President McKinley was the beloved and admired leader of the more advanced party of the most advanced and most expanded democracy that the world has yet seen. It is another of the terribly instructive incidents which must make the unprejudiced observer seriously doubt the success of the great experiment of “government of the people by the people for the people,” of which another of its pilots, and subsequent victims, used to speak so exultingly. It furnishes another item of proof of what has probably always been evident to thinking men, at least to that section not actively engaged in politics, that every system of government devised by man must be strongly tinted with the hues of human weakness. Another startling example of the meeting of extremes in all our terrestrial affairs is offered by the fact, which the history of the last quarter of a century goes to prove, that the respective heads of the absolute despotism of Russia and of the unlimited democracy of the United States of America occupy the most unsafe positions of any public men. The ingenuity expended upon the preparation of weapons of destruction has also contributed to increase the danger of a prospective victim to popular hatred or indignation. The death-dealing revolver can effect the object of its owner, where the stiletto or bodkin could not. And a more widely-diffused knowledge of the structure of the human body is utilised by the educated murderer of the present age to minimise the chances of failure of his deadly design. For the “pen-knife scratch” of the weak-minded and weak-bodied Ravillac, the nineteenth



century substituted the carefully-rehearsed dagger-thrust of Karl Ludwig Sand. This latter politico-religious enthusiast had meditated his act a whole year before its execution, continually prayed for the assistance of God in carrying it out, and died exultingly "for his own convictions" fourteen months after its perpetration. During the year of incubation of his design he had frequently attended anatomical demonstrations in order to make sure of the position of the heart, wrote the most affectionate letters to his parents, was a most lovable companion to his fellow-students—who objected to him only on the score that he was always trying to improve their morals and elevate their religious sentiments—and while under sentence of death always stated with calm dignity that he only "did what it was his duty to do." Although we learn from the pages of Holy Writ that the Jews of ancient times emphasised the importance of smiting an enemy under the fifth rib, this evident aim at the seat of cardiac impulse does not display the appalling subtlety of skill displayed by the assassin of the Empress of Austria, who planted his deadly weapon a step higher and a step nearer to the breast-bone. The thickness of the left ventricular wall may render the infliction of a wound "beneath the fifth rib" comparatively trivial. Wounds of the heart—usually so rapidly fatal—are by no means necessarily so, as popular faith assumes. We have long adopted a triple classification of wounds of the central organ of circulation: (1) *non penetrating*, (2) those so small as to deserve the name of *self-closing* or *collapsing*, such as needle-thrusts, and (3) *valvular*, which pass so obliquely through the cardiac wall as to be closed by muscular action during systole, and by the pressure of the blood from within during diastole. The thinness of the wall of either auricle almost excludes the first and third of these groups, and the choice of the assassin's weapon practically always excludes the second. These facts explain the much smaller recovery-rate in cases of wounds situated at the base of the heart. Even suicides do not usually employ needles, and this fact, combined with the others above stated, goes far to justify strong scientific scepticism regarding the description furnished by the "authorities" concerned regarding the death of Admiral Villeneuve. Even Karl Ludwig Sand missed his own heart, although he had been so successful in his experiment on Kotzebue. Death in cases of wounds of the heart is, of course, in the vast majority of cases, not due to hæmorrhage in the ordinary way, but to the mechanical obstruction offered to the movements of the organ by the blood which has escaped into the pericardium. In this connection the wound and consequent symptoms in the case of the late Empress of Austria furnished what may be looked upon as a typical experiment. There can be little doubt that the assassin of President McKinley also aimed at the heart, "in a general way," in his first shot, and, less definitely, in the second. The penetration of the stomach—before the days of the anti-

septic revolution—almost as surely fatal as that of the heart itself, only much more slow, and infinitely more painful—has, accordingly, been substituted. But, even now the advantages of asepsis and anæsthesia cannot wholly neutralise the effects of a prolonged abdominal operation upon a patient already in a state of complete collapse. Then the use of the Röntgen rays, although giving in so many cases a gratifying confidence in the search for an imprisoned bullet-remains, in such a case as the one now before us, the very serious element of danger from prolonged exposure in various positions of the body. And behind the whole history of such deplorable cases lurks the moral of the "Vanity of Human Wishes," the hitherto complete failure of establishing upon earth a reign of complete "Peace among men." Poverty, misery, and discontent will as surely be met with in the most advanced democracy as in the most absolute monarchy. So will their consequences, physical and moral. The materialism and utilitarianism of the present age have aimed, and with a considerable amount of success, at stamping out all the higher emotions, as their features and results were visionary and unpractical. Superstition and even faith were to be extinguished, as enemies to reason and physical truth. The frequently unsatisfactory results of medicine and surgery drew off the confidence of that advanced section of the community which must see and feel everything before believing. Passion of every kind must be eliminated; emotion must be absolutely controlled; faith must submit to physical tests. This programme has been worked with increasing demonstrativeness during the last half century, and the opening of the twentieth century has at least shown that, with the rapid growth of physical science and the daily inroads on the mysteries of nature, the human race as a whole is still unsatisfied, while its most advanced and most materialistic sections are probably the most miserable of all. The emotional longings for higher things than those of earth will not be exterminated; the hankering after the mysterious and the unattainable—in fact the human characteristics which most truly distinguish man from brute—are still living in the human heart. Their volcanic explosions assume forms ridiculous, preposterous, insane, and even criminal. Medical men should recognise the position and contribute what they can to the education of the public. It is of greater interest and importance to them than to most sections of the community to keep continuously in touch with the advanced guard of thought. Unsatisfied longings and disappointed hopes have on one side created a cosmopolitan brotherhood of Anarchists; on the other a crusade of Christian Science healers.

#### THE ROYAL COMMISSION ON TUBERCULOSIS.

THE promptitude with which the Government has acceded to the popular demand for a Royal Commission, to inquire into the validity of Professor Koch's conclusions in regard to the non-identity of

human and bovine tuberculosis, has elicited universal commendation, and the composition of the Commission is certainly not open to criticism. We must, however, be on our guard against that blind confidence in commissions of inquiry which leads one to regard them as a ready, if somewhat costly and cumbersome, means of remedying shortcomings in our knowledge regarding a given subject. Doubtless this method of inquiry answers very well when the subject to be investigated is one to be elucidated merely by collecting evidence of fact from heterogeneous sources, and when the task before the commission is merely to sift the statements made and to apportion their value. It is quite otherwise when the object is to obtain scientific data, the lack of which is more or less acutely felt. Scientific problems do not often admit of solution at will in this way. But too often, as in the present instance, the discovery of fresh methods of investigation must be the indispensable prelude to satisfactory conclusions, and the initiation of these methods may baffle the most diligent and skilled of observers. Of what possible use, for instance, would be a Royal Commission on cancer? Would it add one tittle to our knowledge or diminish one iota our ignorance in regard to its ætiology and pathological nature? We trow not, and it remains to be seen whether even this highly qualified body of experts will be enabled to carry our knowledge of tuberculosis beyond the point where Koch and others have left it. True they may repeat and confirm or invalidate his experiments bearing on the non-transmissibility of human tuberculosis to cattle, though we doubt if the result will be more than to show that, though possible, such infection is of rare occurrence. The question whether the disease in man and animals is one and the same, so far as it is based on morphological considerations, must be largely a matter of inference, and no conclusion will command assent unless it is borne out by experimental and clinical experience. After all, the principal question which the Commission is called upon to decide is the transmissibility of tuberculosis from animals to man which is of far greater import than its transmissibility from man to animals. Professor Koch was unable to decide this question simply because no experimental data were procurable, and he was fain to fall back upon statistics which, under the circumstances, are notoriously untrustworthy and even misleading. We do not see what means of investigation are open to the Commission which were not available to Koch, and although we do not despair of our ultimately acquiring authentic data on this point we cannot but wonder what fresh line of inquiry the Commissioners can devise with this object in view. Medical literature teems with clinical observations and scientific disquisitions based on a more or less slender foundation of ascertained fact, but on a close scrutiny we find that the absolute gain to science is miserably small. Will the Commission avail itself of the assistance of volunteer "victims" should any such present themselves, or will they

leave Nature to perform the experiments and merely seek to chronicle the results? The worst of Nature's experiments is that they are very slow and they are, moreover, carried out under conditions which are not of our choosing, and of which we are not necessarily cognizant, so that the premises are usually too uncertain to admit of conclusive deductions. Then, too, there is always a margin of difference between experimental results and what may be termed accidental inoculations, which adds to the difficulty of determining the truth. It is evident, therefore, that the data which we are so anxious to obtain are procurable only at the price of long and painstaking inquiry, on a scale, we fear, beyond the reach of any specially-appointed body of experts, hampered by the obligation of formulating a report within a reasonable period. In any event it is idle to look for a report for a long time to come, but in the circumstances the Commission is entitled to disregard our impatience in order to arrive as far as possible at results which will command the assent of the scientific world.

#### A PROPOSED CANCER CLINIC.

THE general newspaper press of the United Kingdom naturally enough keeps a finger on the pulse of the public. Of late it has adopted a progressive, if not always severely scientific, attitude with regard to the prevention of tuberculosis and enteric fever and other infectious diseases. The general spread of knowledge, it may be reasonably inferred, has, therefore, to some extent included the principles that govern the origin and spread of specific infectious fevers. Indeed, such information may be said to form part of the intellectual stock-in-trade of every well-educated layman. For instance, such a man would certainly know that malaria is spread by mosquitoes and consumption by means of tubercle bacilli. This state of affairs is distinctly encouraging, inasmuch as the national administration of preventive science cannot advance far beyond the average standards of popular belief. As regards prevention, it is to be hoped that the present diffusion of knowledge may be the dawn that precedes the full and brilliant light of day. At the same time, it will be wise for the medical profession to keep a watchful eye upon the popular enthusiasm, in order that its energies may be directed into the proper channels. So far as tuberculosis is concerned, the results bid fair in practical importance to equal almost any great advance hitherto made in public health. Stimulated by this success investigators in other branches of scientific medicine are beginning to urge their claims for similar support. In this way appeals have been made recently to the public to establish a special clinic for the investigation of cancer. The proposal is in itself sound, but before it is accepted there are a good many common-sense considerations that will occur to most medical men who are not cancer specialists. Everyone will agree that cancer is a terrible disease, the prevention and cure of which

would be a vast triumph of medical skill, and would confer an unspeakable benefit upon humanity. At present, however, the causation of cancer presents problems of ætiology as obscure as any within the whole range of modern scientific medicine. It is only quite recently, indeed, that there have been signs of possibility, not to say probability, of tracing the ultimate origin of this scourge of mankind. By all means let the nation endow science with the means of investigating cancer in the full light of modern scientific knowledge. On the other hand, however let us remember that there are many everyday diseases that kill hundreds of our fellow-countrymen every year where cancer can reckon its victims only by the score. In some of these diseases, as in enteric fever, the cause is definitely recognised in a specific bacillus. Why should not the popular fury, so to speak, be directed against enteric fever? Or why, arguing on similar lines, should not a declaration of war be made against diphtheria, which has increased so greatly in incidence during recent years. There can be no reasonable doubt that the eradication of both enteric fever and diphtheria could be accomplished by a body of scientific medical men if armed with full powers at all points. That money is not grudged by the public when spent in preventive directions is amply proved by the lavish expenditure that goes on year after year by the Metropolitan Asylums Board in order to provide for notification and isolation of the infectious sick. But the machinery is still imperfect, because it has not succeeded in stamping out, or, at any rate, in reducing to a minimum all the infectious diseases that come within its operation. The point is whether the public would not spend their money to better advantage in perfecting the preventive system at their doors instead of running after every alluring proposal that is drawn across their path. If the amount of money forthcoming for the endowment of scientific research be sufficient to embrace all sorts and conditions of disease, so much the better for everyone concerned. One note of warning may be raised, and that is to keep so-called "specialists" within their own sphere, as men whose range is necessarily more or less limited. In the case of cancer, all the special knowledge attainable should be in the hands of any competent surgeon of experience. The problems of cancer will probably be solved ultimately in the pathological laboratory, whither, indeed, we must look for many of the future triumphs of practical medicine and surgery.

### Notes on Current Topics.

#### Small-pox in the Metropolis.

ALTHOUGH it is satisfactory to be able to record that the outbreak of small-pox in London is now well in hand—the total number of cases up to date being 142—the very fact of its occurrence is sufficiently disquieting in view of the very large amount of inflammable material always present in

this huge aggregation of human beings. There is a large floating population, largely recruited from foreign countries, in respect of which legislation for ensuring vaccination is, and must be, inoperative. Moreover, the unprotected belong, to a great extent, to the poorer classes of foreigners, who are unfamiliar with the godliness of cleanliness, and live under conditions which are at variance with the most elementary laws of hygiene, a fact which this outbreak has once again brought to light. The propriety of compelling the vaccination of all unvaccinated aliens on their arrival in this country is a question the expediency whereof is well worthy of consideration. Another useful measure would be to refuse admission to public schools failing the production of a certificate of successful vaccination. Medical practitioners in this country have few opportunities of becoming familiar with the appearances during the initial stages of the disease that there is a serious risk of early cases being overlooked, thus rendering nugatory the elaborate precautions taken to secure the prompt isolation of infected persons. Even post-graduate classes are unlikely to remedy this lapsus, for obvious reasons, and a very considerable proportion of medical men can lay claim to never having seen a case. We should hesitate to encourage men engaged in active practice to visit small-pox hospitals for the purpose of gaining the requisite practical knowledge, for that would entail the unavoidable risk of their spreading the disease; moreover, the patients whom they would see would, in the vast majority of instances, have passed the stage at which diagnosis presents much difficulty. The only solution that we can see is that in periods such as the present every practitioner should refresh his memory in respect of the symptomatology of small-pox in its earlier stages, and be on the look-out for suspicious signs. Attention should be aroused by the abrupt onset, the high fever, and the early appearance of the characteristic shotty papules, which may be felt on the skin on the inner side of the cheek as early as the third day after the supervention of the fever. It must not be forgotten that various erythematous or mealy eruptions may make their appearance during the interval which normally elapses between the onset and the eruption peculiar to the disease, but as a rule it is sufficient to have clearly before one the possibility of the disease being small-pox to enable an approximately correct diagnosis to be arrived at, and the medical officer of health is there to afford assistance in doubtful cases.

#### Ether v. Chloroform.

WE are so accustomed to the idea that in America, the birthplace of ether anæsthesia, that drug is almost exclusively used as a general anæsthetic, it is with no little surprise that we learn from a recent paper by Dr. Frazier, that he and many of his colleagues in Louisville are ardent advocates of chloroform. The reasons which he advances for this preference are, however, with one exception, not very

convincing. If the anæsthetist understands the methods of administering the one drug and not the other, undoubtedly it will be safer for the patient that he administer that drug with whose action and usage he is familiar. Such considerations can have no weight in deciding the general question as to which is the more dangerous drug for general use. The one point of cardinal importance which must always be kept in mind is that chloroform is at least seven times a more powerful nerve poison than ether, and consequently the margin of safety under it is correspondingly reduced. It is a striking fact how other figures in relation to the two drugs bear out this proportion. Thus, speaking roughly, we find that we use as many ounces of ether for a given length of anæsthesia as we do drachms of chloroform. The percentage mortality of the two drugs is also very instructive. If we combine the statistics collected by Drs. Julliard and Ormsby, we find that ether is roughly five times as safe as chloroform:—

Anæsthetic.	Total number of administrations.	Total number of deaths.	Death-rate.
Chloroform ...	676,767 ...	214 ...	1 in 3,162
Ether ...	407,553 ...	25 ...	1 in 16,302

In the face of these figures there can be but one conclusion, that the routine anæsthetic for general surgical purposes should be ether. While as a general working principle this position is unassailable, it should not for a moment be allowed to interfere with the specialist or limit his privilege to select that drug which under the circumstances he considers most suitable in a given case. As, however, we are apparently far from that time when the administration of anæsthetics will be considered of sufficient importance to demand proper instruction and efficient knowledge, and as such papers as Dr. Frazier's are addressed to general medical practitioners rather than to specialists, we feel it a duty to enter a strong protest against the conclusions which he arrives at.

### Typhoid Bacilluria.

It is only recently that the possibility of enteric fever being spread by the urine of those suffering from that disease has been recognised, and even yet the full significance can hardly be said to be properly appreciated. In the September number of the *Edinburgh Medical Journal* Dr. C. J. Lewis contributes a very interesting paper embodying the results of his investigations in the subject. If the *bacillus typhosus* is found in the urine in an active state it becomes a matter of the greatest importance that this should be sterilised as carefully as the fæces if we are to prevent the spread of the disease. The condition is not easily recognised, since, as a rule, there are no symptoms connected with the urinary apparatus. In a typical case of typhoid bacilluria there is little or no frequency of micturition, no discomfort in the region of the bladder; the urine is acid when freshly passed, and contains large numbers of typhoid bacilli in pure culture with some pus cells

and no albumen. The condition is rarely present in the early stages of the fever, usually not appearing till the third week, and then may continue for a varying length of time sometimes even till well on into convalescence. Occasionally it does not begin till convalescence is established, and then may last for a long time. The question of the frequency of its occurrence is far from settled, some writers estimating it at 25 per cent., others at 6 per cent. or less. As regards diagnosis the only method is careful and frequent examination of the urine. Any cloudiness of acid urine, especially if it appear suddenly, should excite suspicion, and microscopic examination will demonstrate actively motile bacilli with some pus cells if the organisms be present. If fresh acid urine, examined directly it is passed, is found to contain organisms, then bacilluria may be fairly certainly diagnosed. As regards the treatment Dr. Lewis recommends urotropin in ten-grain doses three times a day for two or three days, since this drug is supposed to be excreted by the kidney as formalin, which has a powerful germicidal action. The best method of disinfecting the urine after it is passed is by heat, but carbolic acid 1-20 or perchloride of mercury 1-1000, if thoroughly mixed with the urine and allowed to stand for half an hour, is said to be efficient.

### The Public and the Medical Profession.

THE ordinary layman has pronounced ideas on the duties of the medical profession; ideas begotten and fostered by the self-denying ordinances that the members of the profession so generally adopt and practise. It has come to be looked upon as a part of a doctor's duty to incur expense, personal trouble, and to undergo hardships without looking for any reward. Knocked up at night to go to some sufferer who had been ailing all day, and whose friends postponed calling in assistance until the small hours of the morning; roused without any compunction from his well-earned sleep, the doctor is called upon to go with them. An accident occurs, and the local practitioner is expected to be promptly present. Any delay, any grumbling, is quickly resented by the compassionate public, not one of whom would incur the expense of a fee for the medical visit. But the doctor is expected to not alone visit, but to bestow bandages, dressings, medicine, and so forth, as the case may require, at his own expense. At a recent case in the West of Ireland a lay Coroner had the temerity to lecture a local practitioner for not travelling twenty miles with a wounded man. The journey to the infirmary could be made by rail, the accident occurred on the railway, the local practitioner applied some first-aid dressing to the patient, and sent him to the hospital. At the inquest there was no word of censure for the railway company for not employing the surgeon to make the trip with the wounded man; no thanks given the surgeon who visited the patient and did what he considered best for him. But, on the contrary, the Coroner hoped that "in future, when a

case of such gravity occurs, doctors will not view it with the callousness which is begotten of long association with life and death." We emphatically deny that the members of the medical profession become callous to human suffering. On the contrary, they become more and more sympathetic with suffering. Knowledge and experience makes them calm and self-contained in the presence of danger. They learn to act quietly, quickly, skilfully, in the presence of alarming accidents—a very different condition from the callousness begotten of indifference.

#### Mushroom Poisoning.

It has been said with great truth that in all probability the most dangerous feature concerning the risk of eating of mushrooms is the belief that the tests usually employed in the household are trustworthy. The average housewife is of opinion that she can infallibly detect an edible mushroom by the odour, especially if the particular species of fungus does not blacken a piece of silver while cooking. As a matter of fact the only comparatively trustworthy tests are the botanical characteristics of the fungi. It cannot safely be assumed that the majority of the individuals who gain a precarious living by gathering mushrooms are possessed of this somewhat unusual botanical knowledge, and the reason why more cases of poisoning do not happen is no doubt because the market supply is furnished by people who confine their harvest to a very few varieties of fungi which they know by experience can be eaten with impunity. The supply of mushrooms provided by cultivators of these fungi is in the nature of things beyond question. The individual most to be feared is the amateur or casual gatherer of mushrooms, and under these circumstances it is well to bear in mind the method followed by market-women before any doubtful fungi are prepared for food. The stem is scraped, the gills are removed, and the upper part of the cap is peeled. The fungi are then boiled in salt and water and finally steeped in vinegar. Any toxalbumin that may be present in them is removed by the boiling and the dangerous alkaloid *muscarine* is rendered innocuous by the vinegar. If one may judge from the full notice that this subject has received in the last volume of Sajous's *Annual*, the occurrence of cases of mushroom poisoning have attracted considerable attention in America of late. It is certainly not very comforting to know that Mr. Colville, of the Botany Division of the United States Department of Agriculture, considers that "there is no single test and no safe series for poisonous mushrooms." There is only one rule to be followed in avoiding poisonous mushrooms and that is to make sure that the particular variety is safe because it has been eaten with impunity.

#### The Nutritive Value of Alcohol.

Two experienced investigators have lately given to the world their conclusions on the subject of the

nutritive value of alcohol, and unfortunately the two conclusions are absolutely contradictory. R. O. Neumann, in the issue of the *Munchener Medicinische Wochenschrift* of July 2nd, considers that there can be absolutely no question as to the nutritive value of alcohol, and, in his opinion, alcohol is a true food. On the other hand, H. J. Beyer, in the *Boston Medical and Surgical Journal* of August 22nd, proclaims his conclusion that alcohol has no nutritive value whatever, but, on the contrary, that it causes an abnormal destruction of the protoplasmic constituents of the body. He recommends its use only for the sake of its temporary stimulant effect in cases of extreme fatigue. Beyer bases his findings on the experience he had with five battalions of infantry and 2,300 coolies manœuvring under a tropical sun in a country infested by malaria, the issue of alcohol having been withheld throughout the duration of the expedition, which lasted five months. The conclusions of Neumann are founded upon the results of certain experiments to which he submitted himself. The results of his experiments were practically the same, demonstrating that alcohol is a true food, although not capable of taking the place of fat in every respect. From an examination of Neumann's experiments it is difficult to deny the albumin-saving property of alcohol, and his views have received full support from some personal experiments carried out by Clopatt, and set forth in the *Scandinavian Archives of Physiology*, Nos. 5 and 6 of this year. It must be clearly understood, however, that, although, according to Neumann and Clopatt, alcohol has an alimentary rôle, it must not be recommended for use as such, because it is also a poison when taken in what in ordinary language is termed moderate quantities. There are a sufficient number of scientific arguments against the abuse of alcohol without absolutely denying that alcohol is a food, because, in the face of modern research, this would certainly appear to be proven.

#### Lachnanthes and Consumption.

THE *Times* correspondence in reference to Mr. Alabone's vaunted remedy for phthisis, is still dragging its slow length along. Some of the recent developments have been hardly calculated to add to the dignity of legitimate medicine in the eyes of the public. One of the leaders of the profession, as readers know, wrote to disclaim all knowledge of Alabone and his professed cures of consumption. He further declared that he never heard of the drug called "Lachnanthes," the weirdly named medicament with which Alabone professes to exorcise the demon of tuberculous disease. We publish elsewhere a letter from an eminent authority on materia medica, in whose mind familiarity with this drug appears to have bred contempt. One thing must be evident to all candid men who have a grasp of the principles of modern pathology of tuberculosis, namely, that cure is not to be looked for from any specific drug or combination of drugs. In order that the mind of the public should be relieved

of any impression that Mr. Alabone has not been fairly dealt with by the medical profession, we herewith publicly invite him to declare the nature of his cure for consumption. If so simple a remedy as a preparation of a common American plant can cure consumption then it is clearly the duty of a medical journal to afford every facility in its power to the diffusion of that knowledge. For reasons already given we question the curative powers that are claimed for "Lachnanthes." At the same time we shall be glad to subject Mr. Alabone's reputed cures to scientific scrutiny. We may remark incidentally that after the recent correspondence from leaders of the profession no complaint can ever reasonably be brought against lesser lights of the profession who wish to air their views, wishes, thoughts, knowledge, and aspirations, professional and otherwise, through the medium of signed communications in the public press.

#### Poor-law Nursing.

THE *Birmingham Gazette* of August 31st contains some severe comments on the inadequacy of Union nursing at Walsall. It speaks of the disclosures as "one of the most startling announcements that have been heard of late years in connection with Poor-law administration." If the editor of the enterprising journal had haply been a reader of THE MEDICAL PRESS AND CIRCULAR he would have found repeated comment and exposure of abuses of a precisely similar nature. The attention of the Walsall Guardians was drawn by their medical officer to the fact that a probationer night-nurse in the infirmary had under her charge two wards, in one of which were ten men in a critical condition. The chaplain had a still more "startling" story to tell of a probationer in charge of four wards, one of them containing three delirious patients who kept getting out of bed. The whole thing hinges on the parsimony of guardians who understaff the nursing departments of their infirmaries. The *Gazette*, however, need not go to Walsall for examples of that kind of thing. If we are not misinformed their own large and palatial Poor-law infirmary is managed on strictly economical lines, and a single probationer may be found in charge of three or four wards, sometimes in separate blocks, and holding a certain proportion of acute, dying, and delirious cases. At any rate, we understand that was the state of affairs not many years ago. We shall be glad to have the assurance of the *Gazette* to the effect that the responsible duties of night nurses are now reduced to safe and reasonable limits. The editor might with advantage make some inquiries as to the opinions of the Local Government inspectors upon the matter.

#### A Departure in Mental Hospital Work.

LIKE all other organic diseases, there can be no doubt that mental maladies might often be arrested or cured if brought under medical treatment at their outset. So far as insanity is concerned, the know-

ledge of the fully-developed condition has now reached an advanced position, but a vast deal remains to be learned as to its earlier manifestations. That state of matters is readily explained by the fact that the insane come under systematic medical supervision, as a rule, only when they have attained the asylum stage. Some years ago the energetic Medical Superintendent of the Morpeth County Asylum, Dr. McDowall, attempted to reach sufferers in the earlier stages by opening a department in the asylum whither persons supposed to be suffering from incipient insanity might be taken for advice. The experiment proved a dead failure, because persons afflicted in that way would shun the idea of approaching an asylum for any purpose whatever. Accordingly Dr. McDowall has secured the support of the managers of the Royal Infirmary, Newcastle-upon-Tyne, to another plan, whereby a special out-patient department is opened for the particular class of individuals in question. He himself has been appointed the first honorary physician, and attends weekly. This departure is likely to be of considerable value in filling up the gaps of medical knowledge as regards the early and sometimes curable stages of insanity. The problems or causation, both predisposing and excitant, still require a great amount of investigation in the cure of mental maladies.

#### Nail-biting and Neurosis of the Skin.

SOME discussion has taken place in medical circles concerning a Continental professor's contention that biting the nails was not merely a bad habit but was also a symptom of local asphyxia of the extremities—that is to say, biting the nails was an outward and visible expression of certain pathological changes in the body. This question has been once more brought forward, in the *Meditinskoe Obozrenie*, of June, 1901, by Pospeloff, who holds that nail-biting is a result of a peculiar venous stasis in the ends of the fingers in people so affected, and the gnawing of the nails is only a means of relieving the numb and heavy feeling in the finger-tips. We are not convinced, however, that nail-biting is therefore to be regarded as a neurosis of the skin, but it is certainly worth noting, as Pospeloff points out, that intelligent persons who are addicted to this habit explain that they are impelled thereto, especially when under the stress of emotion, by a feeling of weight and fulness at the finger-tips. It is further advanced in favour of this view that some medical students were observed to be addicted to the habit of biting their nails only when studying hard just before examination, and cases are also reported of patients suffering from Raynaud's disease who exhibited this peculiarity in common with their children, as in one instance where the habit obtained in a woman and in her ten children. All the phenomena in connection with Raynaud's disease have not yet been fully worked out, and until further advances have been made in this respect it would certainly be somewhat premature to dogmatise on a matter of this kind.

### St. Petersburg and Sanitation.

ACCORDING to the well-known Russian physician, Dr. Yakovleff, the sewerage system of the Russian capital is very defective in all hygienic respects; in other words, things are about as bad as they well can be. It is a considerable time since Peter the Great controlled the destinies of Russia, but the wooden drainage canals furnished to St. Petersburg by that ruler are still employed for the disposal of sewage. All water-closets and sinks drain into these wooden pipes of ancient construction, and the natural result is that not only the soil, but also the air, of the city more or less reeks with gaseous abominations. It is therefore scarcely to be wondered at that the annual mortality rate of St. Petersburg is about 30 per 1,000 of the population. Apart from this, it can scarcely be a pleasant city to live in since the tabulated results of a series of experiments demonstrate the continuous presence of sulphuretted hydrogen and other gases in the air at the level of the cellars, and also in dwellings six storeys in height. Samples of the air from the streets and courts and alleys furnished similar results. The quick transit of modern times has rendered the sanitary conditions of all large centres of population of importance to this country, and one cannot but look forward with impatience to the time when some effort to render St. Petersburg less of a menace to the health of surrounding nations will be made.

### Glycosuria and Cigars.

IN the early months of this year the view was advanced (a) that the habitual or excessive use of tobacco not merely determined an exacerbation of existing glycosuria but also, though less frequently, that it might actually set up this condition. The constituent of tobacco smoke, considered to be the causative factor in this relation, was not nicotine, but the carbon monoxide resulting from imperfect combustion; and it was further noted that this tobacco glycosuria was only observed in cigar smokers. The publication of this etiological study of glycosuria has directed a considerable amount of attention to the question, and it has been suggested that the variations in the results of Krehl's examinations made on certain beer-drinking students at Jena (b) are capable of explanation if the existence of a tobacco glycosuria be admitted. The discrepancies in Krehl's conclusions have hitherto been ascribed to different individual dispositions to exhibit glycosuria and to the various kinds of beer, but the whole investigation may have been complicated by the fact that some of the students who were the subjects of observation may have affected pipe-smoking, and others may have indulged in cigars. When the increase in the habit of smoking is taken into account it will be readily seen how necessary it is to arrive at some certain knowledge in this connection with so serious a malady as glycosuria.

(a) H. Stern. *Medical Record*, April 22, 1901.  
(b) Krehl, *Centralb. f. Innere Med.* No. 40, 1897.

### The Medical Congress at Cairo.

FROM many points of view the forthcoming Medical Congress at Cairo should be of considerable interest to the medical profession. The capital of the most ancient land of Egypt is a fitting place wherein to hail the teachings of modern science, for it was there that some of the earliest observations were made that have laid the foundations of the marvellous modern superstructure of modern medicine. It is interesting to note that the 1902 Congress at Cairo will be the first held in a really Oriental country. The increasing relationship of Egypt with the Far East has opened up a more direct interest in the transmission of many Eastern epidemic diseases. Under such circumstances discussions upon plague, malaria, abscess of the liver, cholera, dysentery, ophthalmia, and other specific infections that are mainly of tropical habitat cannot fail to be fruitful. Our knowledge as to the ætiology of tropical diseases has made enormous advances during recent years, owing chiefly to the development of modern methods of research in bacteriological research. A vast fund of clinical observation must be at the command of Egyptian medical practitioners, and it is to be hoped that much valuable matter will be published at Cairo. The Khedive of Egypt has consented to take the movement under his patronage, and by his influence has secured to the promoters of the Congress the solid encouragement of a Government grant.

### The Parent's Right of Veto.

THE parent is universally conceded a right of veto in respect of an operation on his children when circumstances allow of his being consulted, and it is perhaps right that this should be so. The parent, however, who, from prejudice or misdirected affection, refuses surgical aid to his child and thus precipitates a fatal result, is morally guilty of manslaughter, although the law is somewhat ambiguous on the exact degree of his legal responsibility. If medical aid be withheld and death ensues the parent is prosecuted, and it is not easy to trace any technical distinction between the conduct of a parent who refuses medical attendance and one who declines surgical assistance. This point was brought out at an inquest held by the coroner for Cheshire last week on the body of a girl who had a growth in the throat for which an operation had been advised and refused, with the result that spasm of the glottis speedily caused death. The jury could do no more than censure the parents for their heartless conduct, and there the matter rests; but to all right-minded persons the feeling of having, even involuntarily, brought about the death of a child would entail unspeakable anguish, and this may be deemed punishment enough.

### Midwife and Medical Attendant.

THE contemptuous attitude of many midwives towards their duties and responsibilities could hardly be better illustrated than by the facts disclosed at a

recent inquest in London. The evidence showed that a woman was delivered by a midwife of a child, which lived about ten minutes. It was not until three hours later, however, that the midwife thought it desirable to call in a medical man. The latter stated that so far as he could judge from the marks on the face of the child the birth was not normal. The jury censured the midwife severely for her remissness, and there the matter ends. There is a moral, however, to the incident so far as the medical profession is concerned. If these things are done in the green wood what may we expect in the fully grown tree? In other words, now that the midwife has her status certified by an imposing document shall we not find her superior to the whole race of qualified practitioners? It is to be hoped that the coroners will be able to keep a tight hand over the midwife, otherwise a most insidious danger may be introduced into the heart of the community in the shape of a new branch of unqualified practice.

#### Suicides in the French Army and Navy.

THE tendency to self-destruction is peculiarly strong among the Latin races, and is more marked among the men undergoing military service than in the civil population. In the French Army suicide accounted for fifty out of every thousand deaths from all causes during 1900, and this figure represents twenty-seven suicides annually for each hundred thousand men under the flag. This proportion is slightly lower than usual, but is well within the "limits of oscillation." As might perhaps be expected the number of suicides is proportionally greater among the marine than among the land forces, rising to sixty-nine per thousand deaths, and per hundred thousand on active service. Among the various native races serving in the French marines the proportion of suicides is much smaller—only about twenty-four per thousand deaths (fifty-nine per hundred thousand on service). In the Navy proper there are only twenty-six suicides per thousand deaths, equal to seventeen per hundred thousand sailors.

#### Hospitals at the Front.

THE interesting communication which we publish from the pen of Dr. J. B. Coleman embodying his very extensive experience of medical service at the front is, on the whole, pleasant reading after the violent denunciations of which the Army Medical Service has of late been the object; indeed, it is difficult to believe that he is dealing with the same campaign. It is obvious that the shortcomings so bitterly complained of by certain critics were not characteristic of the hospital administration throughout. The importance of disease in weakening forces in the field is but too apparent, the sick outnumbering the wounded in the proportion of twenty to one. The author's remarks on the value of inoculation as a protection against typhoid fever are worthy of note. His returns show a mortality twice as great among the uninoculated as among the in-

oculated, but we must remember that his statistics only bear on a comparatively small number of cases.

#### Orthonitrophenylpropionic Acid.

ACCORDING to the authority of Dr. G. Ruini, the following is a successful method of determining the presence of glucose in the urine. Dr. Ruini has used the reaction for two years, and recommends its adoption. The reagent used is a 5-10ths per cent. solution of orthonitrophenylpropionic acid in 10 per cent. soda solution. Ten drops of the urine to be tested are boiled with 5 c.c. of the reagent. If the liquid turns dark blue 5-10th per cent. of glucose or an equivalent quantity of reducing agents are present. A green colour is observed if smaller quantities of glucose are present, and a bright red colour is seen with excessively large quantities. Albumen has no effect on the reaction, and it is said that the reagent keeps indefinitely unchanged. Full details are given of this test in the *Reforma Medica* of June 25th. To define the reaction more sharply, Dr. Ruini adds chloroform to the cooled liquid, and shakes the test-tube well, with the result that after standing the colour reaction is more marked.

#### Bonesetters and Quacks.

A WIDE publicity has of late been given to the exploits of a certain notorious bonesetter, and his friends have taken advantage of the opportunity to boom his attributes to the utmost. One fact is obvious, *viz.*, that the so-called educated classes are as gullible and as prone to faith in unauthenticated cures as their, educationally speaking, less favoured brethren lower down in the social scale. Patent medicine vendors confidently rely to a very great extent on a *clientèle* derived from the upper strata of society, and their confidence is not belied. There is nothing in this that should cause surprise. Education does not *per se* confer intelligence, which is a congenital quality, improved but not created by education. The wish which is father to the thought is as potent in the breasts of the educated as in those of the unlettered, and credulity is by no means the exclusive appurtenance of any social status.

#### Royal Army Medical Corps.

THE following officers of the R.A.M.C. are "specially mentioned" by the Commander-in-Chief in connection with services rendered in South Africa:—Col. J. A. Clery, Col. R. Exham, Lieut.-Col. T. R. Lucas, Lieut.-Col. F. A. B. Daly, Major S. Westcott, Major R. Kirkpatrick, Major R. J. Geddes (attached East Kent Regt.), Major O. R. A. Julian, Capt. S. G. Moores (attached Scots Guards), Capt. F. Smith (attached Wiltshire Regt.), Capt. H. J. Parry, Capt. J. H. E. Austin (attached Grenadier Guards); Capt. E. M. Pilcher, Capt. W. A. Ward, Lieut. G. G. Delap (attached G. Battery Royal Horse Artillery), Lieut. O. Challis, Lieut. L. N. Lloyd (attached Royal Dublin Fusiliers), Lieut. T. C. Mackenzie (attached Highland Lt. In.), Lieut. T. E. Fielding (attached Mounted In.)



### Medical Reform.

THE interest which is felt by a large proportion of practitioners in the cause of medical reform is evidenced by the copious correspondence in the various organs of professional opinion. We regret that considerations of space prevent our publishing a very thoughtful communication from Dr. Angus Macphee, of Glasgow, on this important subject, which, however, appears in full in several of our contemporaries. Dr. Macphee insists on the unsatisfactory way in which the General Medical Council discharges its duties as the medical parliament of the kingdom—witness the chaos in medical education as a possible result of the half-hearted manner in which the dispute with the London colleges has been conducted. He complains, not without reason, of the inadequate control exercised by the Council over certain departments of medical students' education. Having described the Council as the "medical parliament" Dr. Macphee proceeds to argue as if the Council possessed the legislative attributes of such a body, which is, unfortunately, perhaps, not the case. He suggests, for instance, that the Council should inaugurate the "one portal" system, a step which would be in excess of its statutory powers. The Council might, it is true, frame a Bill to put down quackery, but what chance would the Bill have of becoming law? Dr. Macphee is doubtless in the right when he attributes the halting gait of the Council to the overwhelming preponderance of the nominees of qualifying bodies on the board. We would suggest to him that an alternative to the withdrawal of these representatives, in whole or in part, would be for them to be elected by the constituent members of the licensing bodies instead of, as is now the case, by a "ring" of office holders. In this way we should obtain in large measure the advantage of direct representation while still keeping the bodies in touch with the Council. We agree with our correspondent that it is time the various medical societies of the kingdom took action in the matter. It is only by concerted and collective pressure that we can hope to achieve this measure of reform which is a necessary prelude to the organic measures which our correspondent advocates.

### The Death of Mr. McKinley.

IN spite of the sanguine tone of the ante-penultimate bulletins, our anxiety was maintained with regard to the ultimate fate of the unfortunate statesman whose death we all sincerely deplore. Although a few brilliant achievements in this direction show that recovery is possible after operation, especially if promptly performed, the fact remains that perforated wounds of the stomach are, in the majority of instances, unavoidably fatal. The gravity of the injury is vastly increased when the victim is past middle life, especially if the kidneys are working with a narrow margin. The fatal result in the case under consideration appears to have been due to uræmia, precipitated, in all probability, by a laceration of one organ caused by the bullet. The tissues

failed to display the tendency to heal which the surgeons in attendance had a right to expect, and no attempt at repair had apparently taken place in the wounds. The uræmic process amply accounts for the prostration and cardiac failure which heralded the fatal *dénouement*, and which no medication could possibly hold in check.

### A Good Example.

THE Rev. Richard Wilson, of St. Augustine's, Stepney, is an enlightened advocate of vaccination. A case of small-pox having occurred in some hop fields with which he is concerned, he came to the very sensible conclusion that as many as possible of the hop pickers should be at once vaccinated if an epidemic among them was to be averted. Accordingly every evening in a large marquee at Five Oak Green a concert was given, while in an adjoining tent the vaccination officer was hard at work vaccinating all of the audience who could be persuaded to undergo the operation, he himself setting the example. We commend the rev. gentleman's example to those of his fellows who have the physical as well as the moral advantage of their flocks at heart.

### Medical Practice at the Cape.

FIFTY-SEVEN medical practitioners applied for registration of their diplomas at the Cape of Good Hope during 1900, the number being slightly below the average. Thirteen dentists applied for registration, and three were refused owing to their failure to satisfy the Council's requirements as to previous training and qualifications. A warning having been issued to "dentists and other registered persons" against advertising, it is reported that all the advertisements complained of have been withdrawn, proceedings having been found necessary in only one instance.

### A Statue to Dr. Armauer Hansen.

A STATUE has been erected in the garden of the Bergen Museum to Dr. Armauer Hansen, the discoverer of the bacillus of leprosy, on the occasion of his sixtieth birthday. It is not often that a medical man attains this dignity during his lifetime, but his fellow-countrymen determined not to defer this public recognition of the scientific merit and professional attainments of their distinguished compatriot.

### PERSONAL.

IT is announced that Mr. George Lambert is on the point of resigning the post of Director of Greenwich Hospital, after forty years' service.

DR. C. F. K. MURRAY has been appointed an additional member of the Cape of Good Hope Colonial Medical Council, under the provisions of the Medical Council and Pharmacy Act Amendment Act (1899).

DR. J. E. HUGHES, Medical Officer of Health for the Aberystwyth District, has been presented with a silver cabinet by 1,170 friends and patients on his retirement after 25 years practice in Llanilar. Presents were also made to Mrs. and Miss Hughes in token of appreciation by the donors.

LIEUT.-COLONEL KNOX, of the Royal Army Medical Corps, who has been chief medical officer in charge of the Cambridge Hospital at Aldershot since the commencement of the war, has just retired after thirty-three years' service. He was specially mentioned for services during the Afghan War.

DR. ASTLEY CLARKE and Mr. Hy. J. Blakesley, F.R.C.S., have been appointed Hon. Physician and Hon. Surgeon on the staff of the Leicester Royal Infirmary, vice Drs. Neale and Clarke, recently deceased, a resolution expressive of regret and condolence with the relatives of deceased being passed at last week's meeting of the Board of Governors.

## Scotland.

[FROM OUR OWN CORRESPONDENT.]

### SANITARY ASSOCIATION OF SCOTLAND.

THE twenty-seventh annual Congress of the Sanitary Association of Scotland was held at Paisley, seven miles from Glasgow, on September 5th, 6th, and 7th, and was attended by such a large number of members and delegates that the accommodation of the lecture-hall in connection with the Free Library and Museum was taxed to its utmost when the presidential address was delivered by Dr. Robert Farquharson, M.P. Among those attending the meetings were Lord Dalrymple, C. B. Renshaw, M.P., Provost Cowan, Paisley; ex-Provost Clark, Paisley; Professor Glaister, Glasgow; Bailies Steel, Dick, and Dunlop, Glasgow; Dr. Chalmers, M.O.H., Glasgow; Drs. Duncan, Dewar, and Richmond, Glasgow; Dr. Robertson, M.O.H., Leith; Dr. Robb, M.O.H., Paisley; Dr. Munro, M.O.H., Renfrewshire, &c. Dr. Farquharson, the president, took for the subject of his address "Domestic and Official Sanitation." He referred to the theory put forth by Koch recently at the London Congress on Tuberculosis, with regard to the non-communicability of bovine tuberculous disease to man. He believed that a diseased beast was a focus of infection which should be notified and isolated, and therefore he took exception to Koch's views as expressed recently in London.

#### RECEPTION HOUSES.

Professor Glaister (Glasgow) introduced a discussion on reception houses. He dealt in detail on the law regarding them, their objects, the treatment and supervision of those received, as practised and as proposed, and the proper situation of such houses. An animated discussion followed, in the course of which Bailie Waterston, Edinburgh, said that he looked upon such houses as intended for isolation only. He made reference to medical men not always doing what they preach, as they went in and out among patients of all kinds. He thought there should be no mixing with the public. Mr. Fyfe, Chief Sanitary Inspector, Glasgow, said reception houses should be centrally situated, instead of being on the outskirts of a city. Several other gentlemen took part in the discussion.

#### CONSUMPTION.

Among many interesting papers read was one by Councillor Mallinson, Edinburgh, on "The Duty of Local Authorities with Regard to Consumption." He said that recent discoveries as to the nature and origin of consumption have completely changed the attitude of medical men and the public toward the disease. He believed that if the disease is to be fought and conquered, as it can be, more specific means must be adopted in the future than have been in the past. He advocated compulsory notification, the establishment of bacteriological laboratories by municipal authorities, the distribution of leaflets to all classes, giving information as to how the disease is spread, and explaining the extent of its ravages, the establishment of sanatoria by municipalities, and of hospitals for cases where the patients are bed-ridden and there is no accommodation in the homes for isolation, and, lastly, the compulsory

disinfection of all rooms in which consumptive patients have died. A discussion followed in which Dr. Duncan (Glasgow), Dr. Russell (Paisley), and others took part.

On the kind invitation of the Provost and magistrates of Paisley, a party of from 200 to 300 were driven to Barrhead, where they visited the Corporation Sewage Purification Works. The company was photographed here. Provost Heys, of Barrhead, kindly entertained the company to light refreshments in the Burgh Hall. Following the conclusion of the business the whole company, on the invitation of the Provost, magistrates, and Town Council of Paisley, drove in breaks on the Saturday to Bridge of Weir, where the well-known "Homes" of Mr. Quarrier are situated. After being shown over the "Homes" and "Sanatoria for Consumptives," the company was very hospitably entertained by Mr. Quarrier, who was heartily thanked for the same on the motion of Dr. Farquharson, M.P., seconded by Lord Dalrymple.

## Correspondence.

[We do not hold ourselves responsible for the opinions of our correspondents.]

### LACHNANTHES TINCTORIA.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The plentiful lack of knowledge of the literature of materia medica exhibited by many writers in the *Times* in the recent controversy on the merits and properties of *Lachnanthes* affords conclusive proof of the sad neglect and state of decadence into which the study of pharmacology and the physiological action of drugs has fallen in this country. *Lachnanthes* is a remedy of no importance; it is far more frequently employed by the public than prescribed by the medical profession; but it is neither wise nor expedient to ignore its existence and to have to confess that even its name is unknown. It is humiliating to have one's deficiencies in this respect supplied by some casual chemist or unorthodox practitioner. A want of knowledge of the technicalities, even of the trivialities, of one's calling is an offence not readily condoned by the lay mind. In saying this I am not reflecting on any particular set of individuals, but am simply pointing out that materia medica is no longer cultivated with the same care and attention to detail as is devoted to, let us say, pathology and bacteriology. And this, I think, is a pity, for it is difficult to disabuse patients of the idea that one, at all events, of the functions of a physician is to cure or alleviate disease, and to make himself acquainted with the actions and uses of drugs.

What, then, ought we to know about *Lachnanthes*, and where can this information be obtained? A fairly comprehensive account of its origin and reputed powers is given in King's well-known "American Dispensatory," 18th edition, third revision, (1900) Vol. II. p. 1,112, a work which, if I mistake not, was favourably reviewed in THE MEDICAL PRESS AND CIRCULAR only a few weeks ago. In this comprehensive treatise it is stated that the botanical name of the plant is *Lachnanthes tinctoria*, and that it belongs to the N.O. *Hæmorderacæ*. Its popular names are "red root" and "spirit wood." It is a native of the United States, and grows abundantly in sandy swamps and on the borders of ponds near the Atlantic coast, from Rhode Island to Florida. It flowers in July, and the root is used as a dye. A saturated solution of the whole plant is prepared. In large doses it dilates the pupils, impairs vision, produces dizziness and "other unpleasant symptoms," from which I gather that it is a kind of weak belladonna. As is usual with this particular class of remedy, it is reputed to be an unfailing specific for pneumonia, nervous and typhus fevers, diseases of the brain and spinal cord, delirium tremens, wry-neck, laryngeal cough, tinnitus aurium, and nervous head-ache. The dose is two minims every three or four hours, and for some inscrutable reason, it must be given well diluted with water. Its pharmacological action has not been investigated, and no active principle has been obtained from it. It has been lauded as a specific for consumption, and

people talk wildly of the "Lachnanthes Cure." I am not aware, however, of any authenticated case, and by that I mean a case published, with some approach to accuracy of detail, in which it has proved beneficial. Some seven years ago I tried it, fortunately on a small scale, and obtained absolutely no effect from it even in large and frequently-repeated doses. There is no more reason for employing it in phthisis and other diseases of tuberculous origin than there is for prescribing the thousand and one other drugs which are described in every herbal and dispensatory with equal accuracy and minuteness. I have been familiar with the drug for the last twenty years, and have frequently referred to it incidentally in my lectures at the Westminster Hospital. I have no hesitation in asserting that far better results would be obtained in a case of phthisis from a single week's inhalation of some efficient antiseptic, such as formaldehyde, than from the administration of gallons of such an inert preparation as tincture of *Lachnanthes*.

I am, Sir, yours truly,

Welbeck Street, W.,  
Sept. 16th, 1901.

WILLIAM MURRELL.

#### THE SCHOOL-BOARD AND VACCINATION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.  
SIR,—I suppose most medical practitioners would gladly accept Dr. Garrett Horder's suggestion that no child should be admitted to a Board school unless a certificate of successful vaccination is produced. Were this made a rule and strictly enforced the proportion of unvaccinated children would be reduced to vanishing point, and the spread of small-pox would receive a wholesome check. It is indeed a matter for surprise that no such regulation should hitherto have been put into force. This country, I believe, stands alone in not exacting proof of vaccination from intending scholars—a circumstance which is, to say the least, remarkable in the land where vaccination was discovered.

If the School Board authorities all over the country would adopt this elementary precaution, the other scholastic establishments would doubtless follow suit. In France, where vaccination is not compulsory, there are but few unvaccinated persons owing to the rule in regard to school children, and in respect of the males, all are revaccinated when they enter on their military service, a lesson which was well rubbed in during the Franco-German War.

We are told that School Boards have no legal power to insist on vaccination, an assertion which is open to question in view of the extensive powers conferred upon them in the management of their schools. In any event we can hardly imagine that so obvious a safeguard would be refused by the Legislature.

I am, Sir, yours truly,

M. O. H.

#### THE BIOLOGICAL TEST.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Mr. Edward Berdoo asks, with some *prima facie* show of reason: "Why should pneumonia be more easily diagnosed in a dying or dead mouse than in the man from whom the disease was taken," from which I apprehend he means that the bacteriological test in man should suffice. Although I know little of bacteriology and less of vivisection, I venture to guess as to the former that bacteriologists recognise the non-infallibility of their experiments, and the case of Mr. Berdoo's relative would appear to confirm this; therefore in doubtful cases they think it advisable to inoculate a lower animal as a further test, and supposing no disease is set up in the lower animal from such inoculation, negative evidence would be thereby procured, and their conclusions fortified, and of course this would be an argument in favour of vivisection.

With regard to vivisection itself, about which, as I have said, I know very little, although as I believe, broadly speaking, the objectors base their views on two fundamental principles, viz., the inhumanity, and secondly the inutility, of the system. With regard to the former, supposing that to be their sole objection—in other words that the lives of the lower animals

should be bracketed with and as equivalent in importance to our own, which may be a matter of opinion—morally speaking, we are all bound to become vegetarians. With regard to the latter, viz., its inutility, that is to say, if their proposition is that vivisection is no aid to scientific research—it appears to me for one monstrous. I remember reading many years ago in "Kirke's Physiology" an experiment performed on two dogs with the view of testing the sustaining properties of a purely nitrogenous diet, one dog being fed on beef tea and the other being supplied with no food at all, and the one fed on beef tea perished first from starvation. Would Mr. Berdoo, or any of his disciples, contend that apart from chemical analysis the result of the said experiment served no useful purpose? If so, I will suggest to them that it might be of inestimable value in pointing out in a sick room to the school of that or any other day how much reliance ought to be placed on beef tea as an article of diet in sickness, and surely this must be a matter of public benefaction.

I am, Sir, yours truly,

130, Queen's Road, Peckham, S.E.,  
September 13th, 1901.

#### THE TWIN ICE BAG.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.  
SIR,—Having been informed that there was no special bag on the market for applying ice to the thorax or abdomen of a restless patient, and in my practice having felt very much in need of such an apparatus, I gave Messrs. Arnold and Sons full instructions (dimensions included) to make me what I have termed the Twin Ice Bag, of which a sketch is given herewith, and have found it to answer admirably.



It is made entirely of plain rubber, straps included; it is thereby not injuriously acted upon by the secretions from the body. Having given it a good practical trial I have found it to give complete satisfaction, and I can confidently recommend it to the profession.

The advantages I claim for it are:—

First.—In its application to the thorax back or front; restlessness of the patient does not interfere with its perfect action. The ice or ice water, owing to the two separate compartments, cannot gravitate from the side on which it is required to act. It can be emptied or filled with very little disturbance to the patient, if the night dress is put on so that its opening corresponds to the seat of the ice bag, namely, on either the anterior or posterior surface of the body. It will be seen that on loosening the shoulder straps (not interfering with the waistband) whilst the patient lies on his side and allowing the upper portion of the bag to hang down, removing the stopper, and slightly pressing on the bag, the contents can be emptied into a dish and refilled, with a minimum of disturbance to the patient. If the patient is not too ill to sit up in bed, it will be easier still to empty and fill the bag. The openings in the ice bag are so placed that they are very unlikely to press on the patient, but, if they happen to do so, they are within such easy reach of the patient that he can place them just as he likes.

The application of ice in pneumonia I believe to be the most satisfactory treatment, especially from its effect in controlling the temperature.

Secondly.—In its application to the abdomen, as will be seen, the shoulder straps can be made use of round the thighs, and the appliance in this situation has all the advantages claimed in its application to the thorax. On the abdomen it is not only useful in cases of inflammatory troubles situated in this cavity, but simply as a general temperature reducer I have found it to act very beneficially. I see no reason why this bag should not be applied to the head as well, in cases of refractory patients, using the arm straps under the armpits, and the waistband under the chin.

I am, Sir, yours truly,  
MARTIN J. CHEVERS.

### Obituary.

WE regret to have to chronicle the death of Dr. John Louis William Thudichum, whose death took place at his residence, 11, Pembroke Gardens, Kensington, on the 7th inst. Dr. Thudichum was of German origin, and graduated as M.D. at the University of Giessen as long as fifty years ago. He came to this country and took the diploma of member of the Royal College of Surgeons. After passing several years in general practice he became a member (1860), and later a Fellow (1878) of the Royal College of Physicians of London. Dr. Thudichum's attention was early directed towards what is now known as chemical pathology, i.e., the changes produced by disease in the chemical activities of the human body; and, his work in this direction having been brought under the notice of Sir John Simon, then Medical Officer to the Privy Council, he was employed to conduct a series of researches for the Government, the results of which were published in Sir John Simon's successive annual reports for the years 1868-72, under the title of "Reports on Chemical Researches to Promote an Improved Identification of Disease." At about this time Dr. Thudichum began to turn his thoughts towards the chemistry of wine production; and, in conjunction with Dr. Dupré, he published in 1871 a volume of 700 pages on this subject, which attracted considerable attention and hostile criticism. Dr. Thudichum's next departure was in the direction of the employment of electricity as a curative agent; but he never lost sight of organic chemistry, and published a treatise on the chemical constitution of the brain so lately as in 1886. He was at one period lecturer on pathological chemistry at St. Thomas's Hospital, and from time to time held several professional appointments of secondary importance. Dr. Thudichum had for many years an extensive private practice, and was much esteemed by a large circle of friends; but his activity in the domain of science somehow never realised one's expectations. He was a man of indefatigable energy and a strikingly original turn of mind.

### Literature.

#### MACNAUGHTON-JONES'S PRACTICAL GYNECOLOGY. (a)

THIS excellent book has now reached its second edition. Its chapters are reprints of a series of communications which appeared in the *Edinburgh Medical Journal*, which were written for it by the author at the request of the editor. Practically the entire domain of gynecology is dealt with. It is written in the author's best style, and its value to the consultant is much enhanced by the full reports of interesting cases. This is especially so in the chapter on "Some Pitfalls in Gynecological Diagnosis," which is, perhaps, one of the best in the book, and will well repay reading. In the chapter on "Some Points in Gynecological Asepsis" he labours heavily to out-Herod Herod in his methods and technique. He has succeeded in confusing methods in

(a) "Points of Practical Interest in Gynecology." By H. Macnaughton-Jones, M.D., M.Ch., O.M.I. With Twelve Plates. London: Baillière, Tindall, and Cox. 1901.

a manner that is perfectly bewildering. Having read the chapter, one is at a loss to know what particular method the author really follows. We hardly think it necessary in cases of curettage to follow the author's directions in full "the vagina is thoroughly prepared the day before and the vulva shaved." Why shaved? The therapeutics of disorders of menstruation he treats under the heads of hygiene, medicine, and operation. His hints are very valuable, especially to the busy practitioner; his advice as to the selection of Continental spas is good; we are sorry he did not include and show a preference for our home waters and spas, the medicinal properties of which are equal if not superior to those found on the Continent.

The feature of the book is the new chapter on retroversion; it raises the level to a high standard, and in it he justly recognises the value of the teaching of Prof. Shultz in his book on "Displacements of the Uterus," an excellent translation of which, by Dr. Arthur Moen, late Master of the Rotunda Hospital, was brought out in the year 1888. Dr. Jones's conversion to the teachings therein we gladly recognise. Many beautiful plates adorn this edition, and we warmly congratulate the author on his interesting contribution to gynecological literature. The book is at once interesting, sound, and practical.

### Medical News.

#### Insanity in the County of London.

THE twelfth annual report of the Asylums Committee of the London County Council, which has just been issued, gives a clear view of the general condition of the insane during the year ended March 31st last. On January 1st, 1901, the Council had under its charge 21,369 insane persons, or 24 less than at the same period of the preceding year. The total was composed of 6,432 males and 8,842 females who were certified pauper lunatics in asylums and licensed houses; of 2,689 males and 2,878 females who were imbeciles in the asylums of the Metropolitan Asylums Board; of 151 males and 205 females who were lunatics in workhouses; and of 62 males and 110 females in the care of their own friends. There was an increase of 213 in the number of the certified pauper lunatics in asylums, and of 31 in the number of lunatics in workhouses, with a decrease of 203 in the number of imbeciles, and of 65 in the number of lunatics under the care of friends. A decrease in the total number appears for the first time since the operations of the Council were begun, the average annual increase since 1890 having been 503; so that there appears at first sight some probability that the progress of insanity in the county has at last been overtaken by the provisions made for dealing with it in a satisfactory manner. The statistics in question are, however, to some extent vitiated by the number of lunatics chargeable to the county who are boarded out in other asylums, and the same observation applies to the numbers or ratios of deaths or discharges. In the London asylums themselves the total percentage of recoveries was 36.28 on 3,531 admissions, 9.03 on the average number resident, and 7.33 on the total number under treatment. The percentage of deaths on this last number was 7.56. The report contains a large amount of detail with regard to each of the eight asylums under the control of the Council, and an interesting report from the pathologist, Dr. Mott, F.R.S., whose work and that of his assistants appears to offer increasing probabilities of new light upon the causes and treatment of insanity.

#### Ptomaine Poisoning.

THE death has taken place, from ptomaine poisoning, of the Rev. John Driver, resident priest at St. Joseph's Roman Catholic Church, Bishop's Stortford. Father Driver was seized with illness after eating tinned salmon, and lingered in great agony for a week.

#### St. Thomas's Hospital House Appointments.

THE following gentlemen have been selected as House Officers from the present month:—

House Physicians: L. H. C. Birkbeck, B.A., M.B., B.Ch.Oxon.; V. S. Hodson, B.A., M.B., B.Ch.Oxon.;

J. E. H. Sawyer, M.A., M.B., B.Ch.Oxon. (Extension); J. L. Lock, M.A., M.B., B.C.Cantab., L.R.C.P. M.R.C.S. (Extension).

Assistant House Physicians: W. M. G. Glanville, B.A., M.B., B.Ch.Oxon.; T. W. S. Paterson, M.A., B.C. Cantab., L.R.C.P., M.R.C.S.

House Surgeons: C. A. B. Nitch, M.B.Lond., L.R.C.P., M.R.C.S.; W. H. O. Woods, B.A., M.B., B.C.Cantab.; S. Hunt, L.R.C.P., M.R.C.S.; A. S. Grimwade, L.R.C.P., M.R.C.S.

Assistant House Surgeons: G. A. C. Shipman, M.A., M.B., B.C.Cantab., L.R.C.P., M.R.C.S.; W. Hill, B.A. Cantab., L.R.C.P., M.R.C.S.; T. W. H. Downes, L.R.C.P., M.R.C.S.; F. J. Child, M.A., M.B., B.C.Cantab., L.R.C.P., M.R.C.S.

Obstetric House Physicians: (Senior) H. S. Stannus, L.R.C.P., M.R.C.S.; (Junior) Z. Mennell, L.R.C.P., M.R.C.S.

Ophthalmic House Surgeons: (Senior) H. S. Harris, L.R.C.P., M.R.C.S.; (Junior) F. B. Skerrett, B.Sc.Lond., L.R.C.P., M.R.C.S.

Clinical Assistants in the Special Department for Diseases of the Throat: H. T. D. Acland, L.R.C.P., M.R.C.S.; A. D. Hamilton, L.R.C.P., M.R.C.S. Skin: F. Clarkson, M.B., B.S.Durh.; J. L. Timmins, M.A., B.C. Cantab. Ear: H. Spurrier, B.A.Cantab., L.R.C.P., M.R.C.S.

Clinical Assistants in the Electrical Department: H. T. D. Acland, L.R.C.P., M.R.C.S.

**The Incorporated Dental Hospital of Ireland.**

We regret that Dr. C. E. Boyce's name was accidentally omitted in the list of anaesthetists for the above hospital published in our "Educational Number" last week.

**Belfast.**

THE serious outbreak of typhoid fever which has occurred in Belfast has already been noted in these columns. The following table, which was presented to a meeting of the City Corporation held on September 1st, by Alderman J. Graham, M.D., shows the serious increase in frequency in the occurrence of this disease which has taken place during the past three years. With a record of 505 cases for one month it is imperative that the Belfast sanitary authorities should take steps to ascertain and to combat the cause of the outbreak.

Month.	1899.	1900.	1901.
January	94	42	68
February	54	48	81
March	61	84	79
April	40	95	90
May	58	177	129
June	190	227	247
July	182	206	505
August	253	209	345
September	248	223	—
October	278	230	—
November	103	127	—
December	54	90	—

**The Army and Indian Medical Services.**

THE following official despatches have been *Gazetted*. The first is from Lord Roberts, dated September 4th, in continuation of that of April last, containing a further list of officers, non-commissioned officers, and men serving under his command in South Africa who had rendered specially meritorious service. The names of the following medical officers occur in it:—

- Grenadier Guards: Surgeon-Major E. N. Sheldrake.
- Coldstream Guards: Surgeon-Lieutenant-Colonel J. Magill, Surgeon-Major W. E. Crooke-Lawless.
- Scots Guards: Surgeon-Lieutenant-Colonel G. S. Robinson, Surgeon-Major W. C. Beevor.
- Royal Army Medical Corps: Colonel J. A. Clery, Colonel E. Exham, Lieutenant-Colonel T. R. Lucas, Lieutenant-Colonel F. A. B. Daly, Major S. Westcott, Major E. Kirkpatrick, Major E. J. Geddes, Major O. B. A. Julian, Captain S. G. Moores, Captain F. Smith, Captain H. J. Parry, Captain J. H. E. Austin, Captain E. M. Pilcher, Captain W. A. Ward, Lieutenant G. G. Delap, Lieutenant O. Challis, Lieutenant L. N. Lloyd, Lieutenant T. C. MacKenzie, Lieutenant T. E. Fielding.

Indian Medical Service: Major W. H. W. Elliott, M.B., First-Class Assistant-Surgeon J. Moore, Third-Class Assistant Surgeon R. H. W. Hart, Assistant-Surgeon F. de Santos.

Imperial Yeomanry: 3rd Battalion—Civil Surgeon H. A. Lowndes, Medical Officer; 4th Battalion—Captain R. M. Wilson, Medical Officer; 5th Battalion—Captain E. Davidson, Medical Officer; 6th Battalion—Captain W. J. Naismith (Surgeon-Lieutenant-Colonel Ayr Imperial Yeomanry), Medical Officer; 7th Battalion—Captain F. Wellford, M.B., Medical Officer (since died of wounds); 12th Battalion—Civil Surgeon H. Manden, Medical Officer; 15th Battalion—Surgeon Captain E. Hopkinson, Medical Officer; 16th Battalion—Captain G. H. Reynolds, Medical Officer; 20th Battalion—Captain T. Walcot, Medical Officer.

Volunteers: Elswick Battery (1st Northumberland Volunteer Artillery), Surgeon-Captain J. Wreford, Medical Officer; City of London Imperial Volunteers, Surgeon-Captain R. R. Sleman (20th Middlesex Volunteer Corps); Field Battery, Surgeon-Captain A. Thorne, M.B. (2nd Middlesex Volunteer Artillery Corps); Colonel Lumsden's Corps, Surgeon-Captain S. A. Powell, M.D. (Surma Valley Light Horse Volunteers).

Colonial Corps.—New South Wales: Major W. L'E. Eames (New South Wales Army Medical Corps), Honorary Major A. MacCormick (New South Wales Army Medical Corps), Lieutenant B. J. Newmarch (New South Wales Army Medical Corps), Lieutenant J. A. Dick (New South Wales Army Medical Corps), Lieutenant A. H. Horsfall (New South Wales Army Medical Corps), Nursing Sister E. Nixon.

Civil Surgeons: Mr. W. H. Brodie, with hospital ships; Mr. G. Carré, with prisoners, Simonstown; Mr. Denyer, attached Royal Horse Artillery; Mr. Engelbach, killed in action; Mr. E. T. E. Hamilton, with hospital ships; Mr. T. Kay, attached 6th Battalion M.I.; Mr. R. O. Moon, attached 2nd Battalion Manchester Regiment; Mr. Perkins, Mr. A. Ricketts, attached 12th Brigade Field Hospital; Mr. A. E. Stephens, attached Bearer Company 19th Brigade; Mr. Willis.

Civil Staff, Kimberley: Dr. Smart.

In conclusion (Lord Roberts writes) I wish once more to draw attention to the great civil hospitals in South Africa, which did so much to alleviate suffering and to moderate the strain thrown on the Royal Army Medical Corps, and to the patriotic efforts of Sir John Furley, Lieutenant-Colonel G. S. Ryerson, Commissioner of the Canadian Red Cross Society, and Major W. G. Macpherson, Royal Army Medical Corps, and the Red Cross Society; and finally to bring to your notice the following names, in addition to those previously submitted, of persons who helped to raise and equip these hospitals, and maintain them in a state of efficiency:—

Irish Hospital: Lord Iveagh, the Hon. Rupert Guinness, Drs. G. Stoker and Coleman, and Captain W. T. Mould, Royal Army Medical Corps.

Yeomanry Hospital: Drs. Stonham, Green, Evans, and Sheen; Major G. E. Hale, D.S.O., Royal Army Medical Corps.

Langman Hospital: Mr. J. L. Langman, the donor of this hospital, and his son, Mr. A. Langman; Drs. C. Gibbs and H. Scharlieb.

Welsh Hospital: Sir John Williams, Bart., M.D., Drs. Lynn Thomas, F.R.C.S., and E. H. Mills Roberts, F.R.C.S.E.

Princess Christian's Hospital: Mr. Alfred Moseley, Major H. B. Mathias, D.S.O., Royal Army Medical Corps.

Edinburgh Hospital: Dr. Francis D. Boyd, M.D., F.R.C.P.E., Major Sir James Clarke, Bart.

Scottish National Hospital: Deputy Surgeon-General H. Cayley, Honorary Surgeon to the King (retired Indian Medical Service).

Van Alen Hospital: Mr. Van Alen,

Portland Hospital: The Duke of Portland, Drs. E. G. G. Calverley, C. Wallace.

As this despatch is in continuation of my despatch dated London, April 2nd, 1901, I would request that all the mentions herein made may be considered as bearing the same date—November 29th, 1900—as those in that despatch.

## Notices to Correspondents, Short Letters, &c.

**✉ CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

**REPRINTS.**—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the publisher or printer before the type has been distributed. This should be done when returning corrected proofs.

**ORIGINAL ARTICLES** or **LETTERS** intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication, but as evidence of identity.

**SPES (Exeter).**—Our correspondent will find that formalin is the best.

**TUBERCULOSIS.**—We have ascertained that the work has been long out of print, but doubtless a search among the second-hand book shops would result in a copy being procurable.

**HOPEFUL.**—It is impossible to carry out a research of the kind without being near a large reference library, such as that of the Royal College of Surgeons (Eng.)

**YOUNG MEDICO.**—Three months' introduction we should consider sufficient under the circumstances, but this our correspondent should claim.

### THE PUFF OBLIQUE.

A CORRESPONDENT sends us a marked copy of the *Barnsey Chronicle* for September 14th containing a fulsome notice of a pamphlet written by Dr. Sykes, of that city, on "The Feeding of Infants." If it could be shown that this was done at the instance, or with the assent, of the author we should not hesitate to describe such conduct as professionally reprehensible, since it would amount to advertising. It often happens, however, that over zealous friends do medical men these ill-turns, much to their annoyance, and we should be glad to know that this is the explanation in the present instance.

**MR. J. BEARD (Bradford).**—We hope to have space for your communication in our next.

**MR. C. L. T. (Boston).**—We will look into the matter and report. Thanks for information.

**EDINBURGH STUDENT.**—We understand the new edition of the work in question is a reprint of the last with a few necessary corrections; the book met with such a rapid sale that the authors were not given time to do more than correct trifling errors.

## Appointments.

**ANDERSON, WM. A., M.B., O.M.Ed.,** Assistant Medical Officer to the Plymouth Borough Asylum, Ivybridge, Devon.

**ANDREW, HENRY, L.R.C.P.Lond., M.B.C.S.,** Medical Officer to the Exeter Royal Albert Memorial College.

**CLARKE, ASTLEY VAVASOUR, M.D., B.C. Cantab.,** Physician to the Leicester Infirmary and Fever House.

**COMPTON, ALWYNE T., M.B.C.S. Eng., L.R.C.P.,** Second Assistant Medical Officer to St. Mary, Islington, Infirmary, Highgate.

**DAKIN, THOMAS B., M.B.C.S. Eng., L.R.C.P.Lond.,** District Medical Officer of the Glanford Brigg Union.

**GORNALL, J. GUEST, M.A., M.B., D.P.H. Cantab.,** Medical Officer of Health of the County Borough of Warrington.

**HALLAM, A. E., M.B., Ch.B. Edin.,** Junior Assistant House Surgeon of the Sheffield Royal Infirmary.

**HIPWELL, HARRY, M.D. Bur., M.R.C.S. Eng., L.R.C.P.Lond.,** District Medical Officer of the Barnbury Union.

**MAUGHAN, M. M., L.B.C.P., L.R.C.S.I.,** Medical Officer to the Dublin Metropolitan Police Aid Association.

**MYLES, F. J., M.B., B.Ch.,** Medical Referee under the Workmen's Compensation Act, 1897 and 1900, for the County of Longford.

**PEAKE, ARTHUR E., M.B.C.S. Eng., L.R.C.P.Lond.,** District Medical Officer of the Henley Union.

**STEVENSON, ROLAND A., L.R.C.P.Lond., M.R.C.P. Eng.,** Junior Resident Medical Officer at the London Open-air Sanatorium, Finedon, Berkshire.

**WHITTINGHAM, GEORGE M. Y., M.R.C.S. Eng., L.R.C.P.,** Assistant Medical Officer of the Wandsworth and Clapham Union.

## Vacancies.

**Bradford Royal Infirmary.**—House Physician. Salary £100 per annum, with board and residence. Applications to the Secretary, Royal Infirmary, Bradford.

**British Medical Temperance Association.**—Assistant Secretary. Must be a qualified practitioner, a total abstainer, and able to speak in public. Salary £150 per annum, with lecture fees and board and residence. Applications to the Hon. Sec., Dr. Ridge, Carlton House, Enfield. (See advt.)

**Cork Street Hospital and House of Recovery.**—Assistant Lady Superintendent and Matron. Salary £40 per annum, with board and uniform. Applications to be sent to J. Marshall Day, Registrar and R.M.O. (See advt.)

**County Asylum, Burntwood, near Lichfield.**—Junior Assistant Medical Officer. Salary £50 per annum, increasing to £200, with board, lodging, attendance, and washing. Applications to the Medical Superintendent.

**County Asylum, Mickleover, Derby.**—Senior Assistant Medical Officer. Salary £130 rising to £150 per annum, with furnished apartments, board, washing, and attendance. Applications to the Medical Superintendent.

**East Riding of Yorkshire.**—County Medical Officer of Health. Salary £400 per annum, rising to £500 per annum, with certain allowances. Applications, on forms to be obtained from the Clerk, to be sent to the Clerk of the County Council, County Hall, Beverley. (See advt.)

**Essex County Asylum, Brentwood.**—Junior Assistant Medical Officer, under 26 years of age. Salary £140. Applications to the Medical Superintendent.

**Glasgow University.**—Additional Examinership in Medicine and Science. Annual emolument £30. Duties to commence in January, 1902. (See advt.)

**Guy's Hospital Medical School.** Gordon Lectureship in Experimental Pathology. Salary with fees approximately £250 per annum. Particulars of the Secretary, Guy's Hospital, London, S.E.

**London Hospital, Whitechapel.**—Surgical Registrar. Salary £100 per annum. Applications to the House Governor before October 3rd.

**Manchester, Owens College.**—Junior Demonstrator in Physiology. Salary £100 per annum, rising to £150 per annum. Applications to the Registrar, from whom further particulars may be obtained.

**Margate Royal Sea Bathing Hospital.**—Resident Surgeon. Salary £120, per annum, with board and residence. Applications to the Secretary, Royal Sea Bathing Hospital Offices, 30, Charing Cross, London.

**North Wales Counties Lunatic Asylum, Denbigh.**—Second Assistant Medical Officer. Salary £120 per annum, rising to £160, with board, residence, and washing. Applications to the Clerk of the Visiting Committee.

**Royal London Ophthalmic Hospital, City Road.**—Curator and Librarian. Salary £120. Applications to the Secretary.

**Somerset and Bath Lunatic Asylum, Cotford, Taunton.**—Assistant Medical Officer. Salary £120 per annum, rising to £150, with furnished apartments, board, and washing. Applications to the Medical Superintendent.

**Worcester County Asylum, Powick.**—Third Assistant Medical Officer. Salary commencing at £120 per annum, increasing to £140, with board, residence, &c. Applications to the Medical Superintendent.

## Births.

**ELLIOT.**—On September 9th, at Warwick Square, London, S.W., the wife of Norman B. Elliot, M.D., M.B.C.P.Lond., of a son.

**FERGUSON.**—On September 11th, at 26, Woodland Road, New Southgate, N., the wife of E. Bruce Ferguson, M.A., M.D., B.C. Cantab., of a daughter.

**HALL.**—On September 8th, at Elstowe House, Southampton, the wife of Ed. S. Hall, M.B.Lond., M.R.C.S., of a daughter.

**HEWITT.**—On September 8th, at Queen Anne Street, Cavendish Square, London, W., the wife of Frederic W. Hewitt, M.D., of a son.

**LAUCHLAN.**—On September 12th, at 43, Clapham Road, S.W., the wife of Charles A. Lauchlan, L.R.C.P., of a son.

**PANCRIDGE.**—On September 11th, at Petersfield, Hants, the wife of W. P. Pancridge, M.B.Lond., M.B.C.S., L.R.C.P., of a son.

**SMITH.**—On September 11th, at High Down, Hindhead, Haslemere, the wife of Gilbert Smith, M.D., F.R.C.S., of a daughter.

## Marriages.

**FORTUNE-KENNEDY.**—On September 6th, at Glasgow, Ernest George Fortune, M.B., C.M., F.R.C.S.E., to Sophia Farley, fourth daughter of Thomas Kennedy, Esq.

**HALL-GILMORE.**—On September 5th, at St. Mary's, Great Baddow, E. George Hall, M.B.Lon., to Ethel Mary, daughter of the late Rev. John Gilmore, M.A.

**MACARTNEY-FISHER.**—On September 7th, at St. Margaret's, Lee, Edward Kendrick Macartney, M.R.C.S., L.R.C.P., to Eleanor Maud, daughter of Frederick Fisher.

**MIDDLEMIST-CLACK.**—On September 11th, at Holy Trinity Church, Exmouth, George Edwin Middlemist, M.B., of Moretonhamstead, fifth son of the late Rev. E. Middlemist, M.A., to Mabel Elphinstone, daughter of the late Rev. W. C. Clack, rector of Moretonhamstead.

**MILLER-GILBERT.**—On September 7th, at the Church of St. John the Baptist, Kingston Vale, Putney, G. W. Miller, M.B., Ch.B., to Louie, daughter of H. Gilbert.

**SMITH-WHITE.**—On September 11th, at St. Catherine's Church, Colwyn, N. Wales, John Smith, M.D., M.R.C.S., Brycehall, Kirkcaldy, N.B., to Beatrix Alice, younger daughter of Col. Whitle, J.P., Glan Hafod, Colwyn, N. Wales, (late of Duke of Lancaster's Own).

## Deaths.

**HALFORD.**—On September 12th, at 48, Glenthorne Road, Hammer-smith, Edward Halford, M.D., in the 83rd year of his age.

**HOLLAND.**—On September 3rd, at Chaddle, Cheshire, Joseph Holland, F.R.C.S. Eng., aged 88 years.

**JACKSON.**—On September 6th, at his residence, Ulverston, Lancs., Fox T. Jackson, M.R.C.S., L.R.C.P., aged 35 years.

**ROBERTS.**—On September 8th, at 28, Peel Square, Bradford, William Lake Roberts, M.R.C.S. Eng., in his 56th year.

**TRUDICHUM.**—On September 7th, at Pembroke Gardens, Kensington, John L. W. Trudichum, M.D., F.R.C.P., M.R.C.S., aged 72 years.

**TRACY.**—On September 10th, at Crescent Road, Alverstoke, Hants, Samuel John Tracy, M.R.C.S., L.R.C.P., aged 88 years.

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## Original Communications.

### THE DIAGNOSIS AND TREATMENT OF METRITIS AND ITS RELATIONSHIP TO MALIGNANT DISEASE.

By JOHN CAMPBELL, M.D., F.R.C.S. Eng.,  
Senior Physician to the Samaritan Hospital for Women, Belfast.

#### THE DIAGNOSIS OF METRITIS.

IN considering the inflammatory diseases of the uterus, tubes, or ovaries, it is essential to bear in mind that all these organs are in the closest relationship, both functionally and physically, and that an affection of any one of them is bound to influence the rest to a greater or less degree. Hence in metritis we have to reckon with a simple uterine condition in only a minority of the cases, the adjacent tissues and organs being in the majority also involved, and the diagnosis of metritis being dependent on the fact that the affection of the uterus is the most pronounced lesion we can detect, any others present being subordinate or secondary to it. A grasp of this elementary principle is essential to an intelligent discussion of the subject, and has an important bearing on the question of diagnosis in particular, since errors may arise from the marked prominence of one symptom, which overshadowing all the others, presents a false picture to the mind.

1. *Pregnancy.*—Banking foremost among the conditions which may be mistaken for metritis, we have early pregnancy. When the metritis has produced considerable enlargement and congestion its resemblance to early pregnancy is a close one. The flattened form of the metritic uterus as compared with the globular shape of the pregnant one forms one of the best distinguishing marks. Equally valuable is the recognition of the relative consistence of cervix and body. In the inflamed uterus there is a comparative sameness in consistence between these two parts, both being relatively firm. In the pregnant womb, on the other hand, we notice that the softening process affects the body much earlier than it does the neck, leaving the former soft and somewhat ill-defined, while the cervix remains firm and definite in outline, and, as it were, hinged upon the corpus. If these signs leave any lingering doubt the lapse of time will soon dispel it.

2. *Cancer.*—The character of the discharge in metritis may present a superficial resemblance to cancer, and the appearance of the cervix may also temporarily deceive the observer. The muco-purulent and viscid discharge of metritis contrasts with the red, serous, and foul-smelling flux of cancer. In cases of metritis the edges of the raw surface of the cervix are not hardened, while in cancer they are hard and irregular, and the surface itself presents yellow points. Furthermore the nodular feel of the cervix in metritis can be got rid of by puncture of the Nabothian follicles and glycerine dressings, while the nodules of cancer remain in spite

of such treatment. Finally the extreme friability of the cancerous tissue forms a marked contrast to the resistance of the products of inflammation, and gives us the best guide we have for bedside diagnosis. In malignant cases the sharp curette will remove plugs of tissue, even at an early stage, but will get mere shreds in cases of metritis. The examination of portions removed and prepared for the microscope is of use only as a confirmatory test. It is too cumbrous and uncertain a method for practical clinical use. Whether the disease be in the cervix or body of the uterus, the curette gives the most trustworthy information we can get, and leaves all other methods in the position of mere accessories.

3. *Incomplete Abortion* may simulate metritis, and can only be distinguished with certainty from it by curetting and discovering thus the characteristic placental tissue.

4. *Fibroids and Intrauterine Fibroid Polypi* form a class of cases which may often be distinguished from metritis by the irregular feel of the uterus on bimanual examination. At other times dilatation, followed by the introduction of the finger into the uterus and careful palpation of the uterine walls between the two hands, may be essential to discover small intramural fibroids or intrauterine polypi, and in the case of the latter is much more satisfactory than the use of the uterine sound.

5. *Salpingitis* may cause symptoms like those of metritis, and may co-exist with a secondary metritis or be secondary to an endometritis. Careful vaginal and rectal examination will reveal the tubal nature of the case.

6. *Cystitis* may simulate some of the symptoms of metritis or may be conjoined with it.

7. *Proctitis*, with tenesmus and the so-called "anal leucorrhœa" and sphincter spasm may be due to metritis, or symptoms of metritis may be due to a rectal polypus or other condition.

8. *Reflex Disturbances.*—Different groups of reflex disturbances may be set up by metritis, and may mimic other diseases. Thus cough, shortness of breath, and progressive wasting may simulate pulmonary tuberculosis; or loss of appetite, vomiting, flatulence, and dilatation of the stomach may suggest disease of that organ; or anæmia, palpitation, præcordial anxiety, and vascular murmurs may arouse fears of heart disease; or pains simulating neuralgia may be present; or nervous conditions like hysteria may depend upon the state of the womb. In all cases where the cause of symptoms is obscure the gynaecologist should avoid attaching undue importance to the condition of the uterus, and should carefully and repeatedly examine all other accessible organs; but he should always bear in mind that the uterus should be examined in all cases where a woman persistently complains, no matter of what nature that complaint may be; that disease of the uterus and appendages should be treated at the same time that the symptoms are being attended to, and that the uterus and appendages should not be treated unless signs of real disease are present.

#### THE TREATMENT OF METRITIS.

*Prophylaxis.*—The importance of prophylaxis against inflammation of the uterus is so well recognised that it

requires no advocacy at the present time, when the necessity for care as to the cleanliness of instruments and hands, as well as of the vaginal and uterine canals, is admitted by all who perform operations, major or minor, on women. The management of cases of labour and abortion, however, still leaves room for improvement. The circumstances under which these cases have frequently to be undertaken, as well as the reluctance of the patient and her medical attendant to regard them as essentially operative, are responsible for this, leading as they do to the neglect of a cardinal principle of uterine surgery, namely, that when you have once entered an aborting uterus you should never leave it until it is thoroughly cleared out. Failure to do so is not infrequent, and is partly to be attributed to an antiquated error which has been handed down through the generations by the writers of obstetric textbooks. I refer to the classical description of cleaning out an aborting uterus with the forefinger. Such a feat is, I believe, impossible, as, even under anaesthesia, the finger cannot reach and scrape every corner of a uterus enlarged by pregnancy, and, without anaesthesia, can only make the most futile attempts to do so. Those who remove early placenta in this way as a rule never get beyond the internal os. They are, in fact, removing placenta which are already in the cervix and do not require removal at all, and are in many cases mistaking the contracted internal os for the fundus. No man's finger is long enough or supple enough to thoroughly clean out an aborting uterus. Whenever, therefore, it is necessary to introduce anything into such a uterus a sharp flushing curette should be used, and the whole endometrium carefully scraped.

The patients who suffer from metritis as a result of imperfect evacuation of the uterus at labour or abortion are but a few, though I have mentioned them first on account of the facilities we have for averting their sufferings. For the larger number who owe their disease to indiscretions during menstruation we can do but little in the way of prevention beyond advising mothers to warn their daughters against too active exercises at the periods, especially such as involve much abdominal movement, and insist on the use of some good absorbent pad while the flow continues. To the great army of women who suffer from gonorrhoeal metritis we have no preventive to offer. They seek our aid when the uterus is already involved. They are subject to repeated re-infections. So far as prophylaxis goes they are beyond our reach. The prevention of metritis is, therefore, a matter over which we have but a limited, though an important, amount of control. In spite of our best efforts the disease will remain with us, and the question of its treatment will exercise the ingenuity of the profession in the future, as it has done in the past.

#### 1. GENERAL TREATMENT.

There can be no question about the utility of immobilisation of the uterus by an abdominal belt, so far as that is possible; about the avoidance of fatigue and strain; about avoidance of sexual intercourse; about the use of laxatives and dieting, or of glycerine or water enemata or of glycerine suppositories to aid evacuation of the bowels; or about the advantages of general tonics and of the natural medicinal waters, the ferruginous for the anæmic cases, the alkaline for dyspeptic patients, and the indifferent and sodium chloride waters for the neurotic.

2. *Douches* are undoubtedly useful, but require to be used more energetically than they mostly are. The amount of water should not be less than two quarts for each douche; the duration of its application at least twenty minutes; the temperature should be gradually raised from 100° F. to 120° F., the frequency should be at least twice a day; the position of the patient should be dorsal with the hips well raised, and the residue should be carefully evacuated from the vagina after each douche. To gain any real effect from them hot douches need to be continued for months. *Hip baths* are also of some service, especially when a bath speculum is used, but are inferior to douching properly done.

3. *Tampons*.—The advantages of the tampon have been much overestimated. Whether they be soaked in plain glycerine or in solutions of ichthyol or other medicament in glycerine, appears to be immaterial. In any case to be of use they require to be inserted much more frequently than is customary. In fact, a daily application is necessary.

4. *Local Bleeding* is, in some cases, beneficial, especially where the cervix is chiefly involved. It is best done by puncture followed by warm douching, and needs to be repeated every second day until the congestion has decreased.

The application of *leeches* is quite inferior to puncture.

5. *Intra-uterine Medication* is of more importance than any of the foregoing methods, and includes (1) the application of antiseptics, and (2) the application of caustics to the uterine cavity.

6. The "galvano-cautery," the "thermo-cautery," and the "actual cautery" deserve no commendation.

7. Neither does "atmo-causis," for the application of steam to the endometrium is an unnecessarily severe and dangerous proceeding.

8. *Curetting* is, of all the methods of treating metritis, admittedly the best. It is, however, not generally recognised by the profession or by the public that the mere scraping of the uterus is not in all cases sufficient to effect a cure or even a marked amelioration of symptoms. The fact that metritis is often a very chronic and intractable complaint is lost sight of, and the patient is encouraged to hope that the operation "will make her right."

Frequently it does not do so, and the operation or the operator is discredited. Now the truth is, that in most cases of chronic metritis the curetting is merely the *first step* in a course of treatment which ought to be sufficiently prolonged to materially influence the disease. Curetting, therefore, requires to be reinforced by one or several of the other methods, as well as by the removal of complications if such exist. As at present carried out, the operation is preceded by cleansing of the vaginal and uterine cavities by antiseptic lotions, and followed by the application of caustics or styptics to the uterus for a comparatively short time, according to the views of the operator. My contention is that patients should be taught to expect more prolonged subsequent treatment, both general and local; that, in fact, the treatment, like the disease, should be somewhat "chronic." Besides this question there are some others worthy of discussion, as they give scope for some difference of opinion, such as the "curette" to be used. Opinion as to whether it should be blunt or sharp still varies. The sharp one is, I think, to be preferred. With it a greater or less effect can be produced according to the amount of force used. The operator has thus a chance of using his discretion, which he has not when the instrument is blunt. The time at which the operation is done is, perhaps, not of much importance. Undoubtedly dilatation is easier immediately after a period, but on the other hand, in cases of hæmorrhage or dysmenorrhœa, a good deal may be gained by curetting a week or ten days before the period. Certainly the latter time is the best for cases in which sterility is an important factor.

The question of anaesthesia depends on the amount of dilatation needed, as well as upon the nervousness of the patient. The dilatation and not the scraping is usually the painful part, and some relief can be obtained by cocaine in 10 per cent. solution applied to the cervix and cervical canal for ten or fifteen minutes beforehand.

Preliminary vaginal antiseptics in the form of thorough douching night and morning with 1 in 2,000 sublimate solution or other efficient agent, and two fingers in the vagina is essential to safety. This can only be done by a specially trained nurse. Neither the patient herself or an ordinary trained nurse can give a proper cleansing douche.

The operation may be performed with the patient on her left side, but the advantages of the dorsal position are so great that it should be universally adopted. It renders the operation both easier and safer. The steps of the operation afford little scope for controversy.



When the patient has been placed in position the vagina is scrubbed with soap and water and a tooth-brush, green soap which has been sterilised by heat being the best. An antiseptic douche follows this. The speculum is then introduced, the cervix lowered by a volsellum, and the sound passed to ascertain the direction and size of the uterine cavity. If the canal is wide enough the curette may be used without dilatation. If not, the dilatation is best accomplished by long-handled dilators, such as Duncan's, because the length of the handle and the curve enable the instrument to be introduced with less disturbance of the uterus than the shorter ones like Hegar's give rise to. Extreme dilatation is unnecessary; indeed, in most cases dilatation beyond No. 16 of Duncan's instruments is accompanied by laceration, and should only be resorted to in cases of uncertain diagnosis where the introduction of the finger is essential. Dilatation is followed by flushing of the cavity with an antiseptic solution, 1 in 2,000 sublimate being the best. The curette is then applied, and with a sharp instrument the force must be modified to suit the state of the case in hand. The *débris* having been washed away through a double-channelled uterine catheter, the cavity is dried out with a strip of sterilised gauze and swabbed or injected with perchloride of iron or some preparation of iodine according to the amount of bleeding. Irrigation of the uterus and vagina follows this, and then a vaginal plug of iodoform gauze is inserted and allowed to remain for two or three days, when it is removed and vaginal douches given night and morning for a week. After this further treatment is unnecessary in cases of catarrhal metritis, but in the granular form intrauterine injections of iodine every second day for eight or more times will be needed.

The danger of the curette nowadays is very slight, but certain accidents may occur. Perforation appears to be rather frequent. A good many instances have been published, and the accident has happened to most men who have performed the operation many times. It is most likely to occur when the exact curve of the uterine cavity is not continually borne in mind during the operation, hence the necessity for carefully passing the sound before commencing to dilate or curette. The accident is practically free from danger when the operator recognises what has occurred and desists from further treatment. Hemorrhage seldom follows the operation in cases of metritis. It is more likely to succeed an imperfect curetting than a thorough one. Its importance lies in the fact that the possibility of its occurrence should deter us from being too ready to curette in our consulting rooms. Peritonitis will only occasionally follow the operation when it is done intelligently.

10. *Electrolysis* is a tedious method of attaining ends which can be better compassed by other means, and has little to commend it.

11. Among the more recent things which have been used for gonorrhoeal metritis and vaginitis the "Yeast Method" deserves mention: 10 c.c. to 20 c.c. of fresh beer yeast mixed with a small quantity of beer is injected every day or every few days into the vaginal fornix, the vagina having been previously cleansed and dried. A tampon is subsequently introduced. Its efficacy depends on the antagonism of certain micro-organisms. It is no improvement on other plans of treatment.

12. In chronic cases, where there is evidence of old venereal disease, the application of mercurial ointment to the uterine cavity may be beneficial. It is applied apparently with advantage to the male urethra in cases of intractable gonorrhoea with small urethral ulcers, and possibly it might be equally serviceable in the uterus.

#### TREATMENT OF COMPLICATIONS AND SEQUELÆ.

The treatment of certain complications and sequelæ of metritis demands a passing notice.

1. Mucous polypi of the cervix may require removal by forceps or curette, with subsequent application of perchloride of iron or of the thermo-cautery.

2. The so-called "ulcerations" of the cervix often require prolonged treatment even after the uterus has

been curetted. When they are recent, and there is not much thickening of the cervix, they will yield to curetting, followed by solid nitrate of silver for a few times, and subsequently by boric acid dressings. This produces a rapid change in the condition, and is superior to such remedies as tincture of iodine, weak nitric acid, chromic acid, chloride of zinc, acetic acid, pyroligneous acid, &c., on the other hand, for old standing erosions with much chronic thickening caustics are worse than useless. In such cases the excision of the diseased portion, followed by the union of the vaginal to the uterine mucous membrane is the best treatment (Schroeder's operation).

3. A third set of cases includes those in which there are lacerations as well as erosions. According to the amount of thickening present these will demand repair of the lacerations in the less hypertrophied examples (Emmet's operation) or amputation of the cervix when the enlargement is more pronounced (Schroeder's operation).

#### VARIETIES OF METRITIS REQUIRING MODIFIED TREATMENT.

Two varieties of metritis are deserving of special attention as regards treatment, namely, the hæmorrhagic and the chronic painful metritis. For the hæmorrhagic form the recumbent position, hot douches, and the administration of the liquid extract of ergot, or still better the fresh infusion, or ergotine, are unquestionably useful. *Hydrastis canadensis* is of doubtful value, and *digitalis* is effective only in cases complicated by heart disease. Laminaria tents and plugging the vagina for uterine hæmorrhage are obsolete. Of the more active measures the injection of perchloride of iron, or still better curetting followed by the injection of perchloride of iron, together with the repair of lacerations and removal of other complications, yield the best results. But even such energetic treatment will have but a temporary effect unless it be followed by repeated injections of iodised phenol and the prolonged use of ergotine. In bad cases plugging the uterus with plain sterilised gauze or with iodoform gauze may be required until the patient rallies enough to be able to stand the curetting, or plugging with gauze soaked in 50 per cent. chloride of zinc solution may render curetting unnecessary.

Chronic painful metritis is one of the most troublesome forms of the complaint. In it a certain amount of benefit will be derived from scarification and puncture, followed by the use of glycerine and iodine or glycerine and ichthyl tampons. The virtues of ichthyl are, I think, very doubtful. The so-called "Columnisation" of the vagina by filling it with cotton wool or clay or sheep's wool has some good effect, especially if sheep's wool soaked in glycerine be the agent used. Hot douches are particularly serviceable in these cases.

Ignipuncture gives no permanent good result.

Electricity is uncertain, as is also massage of the uterus.

Among operative measures amputation or repair of the cervix may be required, but removal of the ovaries, or of the uterus, with or without the ovaries, yields poor results, owing to the neurotic tendencies of most patients thus affected.

#### THE RELATIONSHIP OF METRITIS TO MALIGNANT DISEASE.

The relationship between metritis and cancer of the cervix has not so far been demonstrated beyond question, but the evidence in favour of its existence is strong. The connection between metritis and cancer of the body of the uterus has been definitely settled. We know certain facts about cancer which have a bearing on this subject, e.g., cancer is more common in women than in men. This frequency manifests itself between puberty and the menopause, especially between forty and fifty years of age. The uterus is the organ most often affected. The cancerous tendency is influenced by race, whites being more liable to it; by heredity, though evidence on this point is open to question; by age, and by the struggle for existence, including want, worry, and painful emotions, and everything calculated to depress the general health. About these general considerations

there can be no doubt. We are now, however, more concerned with local influences. Cancer of the cervix appears to be predisposed to by lacerations; by cervical metritis, especially of gonorrhoeal origin, and by frequent parturition, factors which are largely dependent on one another. The proof of their influence is the relative immunity of nulliparæ from cancer of the cervix. We have no direct evidence that the typical glandular proliferation or "simple adenoma" passes into the atypical proliferation or "malignant adenoma," in other words, into an epithelioma of the cervix.

Cancer of the body of the uterus, which is a disease both of the parous and nulliparous, has had its connection with metritis more thoroughly worked out. The transformation from endometritis to cancer has been followed step by step at successive curettings. (1) A slight glandular endometritis when aggravated becomes (2) a benign adenoma, i.e., a typical glandular endometritis, with a single layer of epithelium and normal interglandular tissue which degenerates into (3) malignant adenoma, an atypical growth with a single layer of epithelium and the interglandular tissue gone, and this is the first step towards cancer, where the glands form solid cylinders filled with cancer cells. The recent observation that the uterine glands in their deepest ends normally contain solid masses of cells is rather disconcerting, as glands blocked by proliferation of cells can be no longer regarded as evidence of commencing malignant disease. Primary cancer of the "body" is special to women who have passed the menopause, and, on that account, hæmorrhage in them calls for the immediate use of the curette as a diagnostic instrument.

In this connection it is important to remember that epithelioma and chronic metritis may exist in the same uterus. Hence the necessity for examining many pieces of scraping before making the diagnosis.

## Clinical Lecture

ON

# THE PRESENT STATE OF OUR KNOWLEDGE OF AUTO- INTOXICATION.

By DR. JOSEPH KOVACS,

Senior Assistant at the Principal Clinic of Budapest.

[SPECIALLY REPORTED FOR THE MEDICAL PRESS  
AND CIRCULAR.]

It is generally known that Bouchard was the first to call the attention of physicians to the fact that under certain circumstances the urine contains some toxic constituents, and from this fact he has drawn the conclusion that these toxic matters must be circulated in the blood, where they are also formed. French and Italian physicians investigated the question with the greatest accuracy, and endeavoured to explain these phenomena on chemical grounds. This elucidated the fact that not only during the normal process of digestion, but also in certain pathological conditions, various chemical substances are formed in the stomach and intestines (phenol, streptotoxin, volatile fatty acids, alkapton), which bodies, when injected into the bloodstream of the animal experimented upon, gave rise to very striking and characteristic constitutional symptoms.

These phenomena are similar to those of poisoning, and, on account of the poison being in the organism itself, the group of symptoms thus arising received the name of "auto-intoxication."

Later on it was elucidated that the toxic matters which have such a deleterious effect upon the tissues of the organism, can be also formed in other parts of the organism. Especially is this true regarding the intermediary and final products of metabolism (acetone, diacetic acid, lactic acid, oxybutyric acid, and amylobutyric acid). The last-mentioned source of

auto-intoxication, being formed by the metabolism going on in the tissues themselves, the pathological symptoms arising therefrom were given the name *histogenetic* or *interstitial* auto-intoxication. This much therefore is certain that among the different phases of metabolism chemical substances are produced, which have a deleterious effect upon the organism by virtue of their chemical toxicity.

Now the only question remaining undecided is what may be the cause of the fact that the toxic materials, permanently present in the organism, are in one case active and in another absolutely inactive. The explanation may be: first, that these chemical products being very changeable, are decomposed, and later on unite with other products of metabolism and in such a way they are harmless; secondly, that the organism has under its command certain bodies that defend, it which hold the enemy in check, and so these poisons are eliminated from the organism.

It is evident, however, from the preceding that whilst demonstrating the chemical ground of auto-intoxication no light had been thrown on the dimly lighted territory of pathology.

In the first Internal Clinic of Budapest, Korányi Sandor initiated extensive investigations for the determination of the osmotic relation of sick and healthy men (1893). From these investigations it became clear that the molecular concentration of the normal blood is strikingly constant (0.56), and so we were justified in supposing that the functions of single organs are best carried on by this physical state of the blood. On the contrary, it was evident that in diseases in the course of which auto-intoxication occurred in its most striking form, the osmotic pressure of the blood was increased to the highest point.

Particularly we found this great physiological alteration of blood in the various forms of nephritis, also in several cases in the course of the development of uræmia. Similar results have been afforded by investigations carried on on chlorotic patients. These led me to the conviction that the physical alteration of the blood of chlorotic patients was very closely related to that taking place in nephritics, and at the same time, under the influence of these diseases, symptoms very much resembling the *uræmic* signs of nephritis have set in. In a contribution, published at a corresponding period, I described the results of my investigations on this subject, calling attention to the fact that the characteristic symptoms of anæmia and chlorosis can be traced back to auto-intoxication.

On the other hand, nothing was more natural under such circumstances than to suppose that the auto-intoxication stands in a close relation to the changed physical alterations of the blood and of the juices of the organism, and acting on this supposition we have laid the foundation of the further study of auto-intoxication. For in order to decide this question more accurately I made some further investigations, in which I took into consideration the osmotic relations as well. I injected the urine of chlorotics (having a low molecular concentration) and the urine of patients suffering from heart disease (possessing a high molecular concentration) into hares. Similarly I used in several cases hæmoglobinuric urine. With the urine of chlorotics I could not produce any abnormal symptoms on hares, but, on the contrary, with the urine of patients suffering from heart disease I observed the well-known symptoms of auto-intoxication. Furthermore, it was striking that from hæmoglobinuric urine I succeeded more easily and rapidly in producing the symptoms of intoxication.

I am, therefore, justified in concluding from these experiments that the osmotic pressure undoubtedly

has some connection with the urotoxicity, but I had to keep in view that other factors must also play some role in this matter. For instance, among the constituents of the hæmoglobinuric urine the potassium salts prevailed; therefore, I believe that these salts have a great influence upon the degree of urotoxicity. The results of my numerous investigations closely tallied with the experimental results Korányi Sandor attained on uræmic patients. In some of his cases too the osmotic pressure was proved to be very high, but there were also others that showed the reverse.

My investigations, with regard to urotoxicity, I had to then abandon owing to many calls on my time in other directions, but later on, in 1900, I again commenced to deal with this question. This time I could carry out my experiments far more easily. The starting-point of these last investigations was that there exists some connection between osmotic pressure and the urotoxicity of the urine. For my experiments I used hares and mice; I injected the urine of pneumonics (in an unchanged condition) and the urine of pneumonics and others previously rendered isotonic, together with isotonic salt solution, and finally isotonic salt solution, together with unchanged pneumonic urine. By these experiments I hoped to be able to prove undoubtedly the efficacy or inefficacy of the osmotic pressure. The result attained on mice I cannot put forward as trustworthy, because most of the animals suffered severely from the injections, although this much is certain, that under the injections of salt solution none of the animals died, whilst fifteen to thirty minutes after the injection of unchanged urine of pneumonics all the animals died. It is important also to note that the urine of pneumonics after the crisis proved to be much more toxic than during the course of the illness.

The fluid injected into the animals was equal to a third part of their weight.

And now, after reviewing my experimental data, whilst searching for the active agents of urotoxicity, and supposing these urotoxic agents (evacuated in and extracted from the urine) to be circulating in tissue fluids, my conclusion is justified, that the osmotic pressure, as well as the chemical constitution of these agents have some influence upon the production of auto-intoxication. It must be remembered, however, that there are also other active agents, such as potassium salts, and no doubt others as yet unknown. Besides the supposition is that these agents can support each other in their effects; *my experimental data at least seem to prove this cooperation. It seems sure that each of the above-mentioned components aid in the production of auto-intoxication.* What cannot be demonstrated is what share they respectively take in the phenomenon.

The efficacy of the osmotic pressure is proved by the experimental fact that the red blood corpuscles seem to be extraordinarily sensitive to osmotic pressure.

I think the following case is a very instructive one, rendering good service in the explanation of this nebulous question.

Two months ago a patient was admitted into our hospital with the following symptoms:—On the first two days headache, uncontrollable vomiting, great prostration, the pupils were contracted and reacted very sluggishly; respiration normal; pulse beat 90; temperature tending to subnormal. Partly on account of these symptoms, partly by means of exclusion, we thought we had to deal with uræmia. The examination of the urine did not verify this supposition ( $\frac{1}{3}$  per cent. albumen, kidney epithelium being present, but without cylinders). Examination of the blood demonstrated, that the freezing point had sunk to 0.72. Patient was

soporous, and later on comatose. On a second examination of blood and urine the results were similar; therefore, we thought it necessary to administer an enema of physiological salt solution; this was followed by striking improvement, which lasted forty days; then periostitis has set in, and also pneumonia with endocarditis and fever (39 and 40° C.). During the feverish condition albuminuria was present just as at the time of the admission of the patient. Fourteen or fifteen days after the onset of the fever the patient died. The autopsy showed no nephritis, but parenchymatous degeneration of the kidney; evidently it was a case of *uræmic intoxication with an expressed clinical image, with uræmic blood without nephritis.* It is impossible not to observe here the connection between the high osmotic pressure and the expressed pathological image of auto-intoxication; and although this case cannot be used for the decision of the question as to whether the matters, kept back on account of the renal insufficiency, poisoned the organism by reason of their osmototoxicity or by their chemical effect; yet the supposition can almost be excluded that chemical or biological toxins that had accumulated to an extent corresponding to this high molecular concentration, would be able to cause the intoxication of the organism. It can be more easily understood, that here not a single, but different protoplasmic poisons were acting, among which the excessive osmotic pressure must certainly have a certain role, and this can with facility be brought in accordance with the above-mentioned experimental facts.

Posner and Vertun sought the source of urotoxicity and auto-intoxication almost purely in the osmotic pressure, this being gathered from their communication published in 1890 in the *Berliner Klinische Wochenschrift*. The Paris School, and especially the pupils of Bouchard, described the result of their investigations in the same year, and they likewise apply the name of "l'osmototoxicité" to the toxic effect of the osmotic pressure.

The auto-intoxication, therefore, which during the last decade constituted the most diligently cultivated part of pathology started at first from our Clinic, and being carried on also at other clinics it gained a new foundation by showing the existence and action of auto-intoxication, without, however, the older hypotheses being cast off. There are in progress, however, still more recent investigations from which, as seems indicated, we can expect further light to be thrown on this very occult question: I mean the searching after toxic matter, which are the products of internal secretion.

### ON TIME-SAVING METHODS OF TREATMENT IN PHTHISIS, WITH A PRELIMINARY NOTE ON THE "SILVER TREATMENT" OF PHTHISIS BY INTRA-INJECTIONS OF PROTARGOL. (a)

By WM. EWART, M.D. Cantab., F.R.C.P.,  
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It is now recognised that phthisis is curable by the open air if sufficient time be allowed. Our next effort should be to shorten the cure, and this communication is an endeavour to promote the search for more expeditious methods, without which the complete realisation of the scheme of State-aided relief cannot be carried out owing to the vast numbers to be dealt with and to the costliness of the necessary accommodation and of the treatment and diet. Much, therefore, would have been achieved

(a) Abstract of paper read before the British Congress on Tuberculosis, August, 1901.

if the individual stay at State sanatoria could be shortened; and this achievement is claimed as possible if the cases of phthisis (excluding always hopeless cases) were to be provided with adequate preliminary treatment such as to fit them to secure from Sanatoria the maximum good in the minimum time.

Quite recently strong claims have been put forward in favour of various methods of treatment. Special notice would seem to be due to those with pretensions as "specifics," most of which probably do some appreciable good, even though not fulfilling their entire promise. A strong plea must therefore be entered in the interest of the rate-paying public as well as of the patients for an adequate inquiry into the comparative capabilities of the various "cures" now available. It is clear that we cannot rest satisfied with our present system, however great its advance upon previous conditions.

*The "Thorough Treatment" or "Hospital Treatment" as a preliminary to Open Air or Sanatorium Treatment.*—Early and mild cases in strong subjects are practically self-curable with an open-air life; but with the large group of pyrexial, sub-pyrexial, or more or less chronic phthisis, the open-air treatment, at any rate in this country, and also the climatic treatment, so it would seem from Alpine experience, is not the shortest way to a cure. Nay, many cases are at first ill-suited for it. In these cases progressive tuberculosis is perpetuated by the catarrh. A great deal of the latter is remediable by what may be termed the hospital treatment, or "thorough" treatment, the object of which is to rid the case as soon as possible of its dangerous complications—bronchitis, catarrh, caseation, and suppuration—whilst utilising the period of unavoidable confinement in bed, in the ward, or in an even temperature, for the application of every therapeutical influence which in the individual case may be profitably resorted to. This idea has been recently carried out with an encouraging degree of success in a limited number of cases. The favourable results obtained have demonstrated to my satisfaction the advantage of not sending the patients to the open air prematurely, but only in a convalescent state.

*The Direct Pulmonary Methods, including the Intravenous.*—In addition to serum therapy, which belongs to the future, these include the intratracheal injections, which are not sufficiently recommended by their results: the inhalation treatment, well known to all in its more familiar applications, but specially elaborated into definite methods by Cervello with only partial success as the formaldehyde system, and more recently with every promise of practical usefulness by Dr. George Stoker as the continuous nasal oxygen inhalation method; and, lastly, the intravenous injections, which in some form, perhaps quite different from any at present in use, are likely to prove the most active and rapid agency. Landerer's sodium cinnamate treatment has had a fair trial, and the bulky injection method which we owe to Dr. Maguire's labours is now being tried. I am not acquainted with the latest development of the formaldehyde injection treatment, but some of the results obtained with the original method were very favourable, although neither by this nor by any other method has a permanent clearance of the bacilli from the tissues been obtained.

I was led to substitute protargol for formaldehyde by the conspicuous success of the administration of nitrate of silver in pneumonia (Caccianiga) and of its subcutaneous injection in phthisis (Mays) Pending the discovery of some better remedy I have provisionally adhered to it in preference to formaldehyde because of its more decided, of its more rapid,

and of its more lasting action. The clinical effects resemble those obtained by Dr. Maguire with formaldehyde—viz., a remarkable subjective feeling of improvement coinciding with manifest improvement in aspect and in strength, a rapid diminution in the cough and in the expectoration, and a more or less rapid change from the dense sputum of phthisis to simple catarrhal sputum and ultimately to hyaline mucus, &c.

The ultimate effect is to lower the temperature, but meanwhile the level may be disturbed by elevations incidental to the treatment. More often than not the injection is followed after one hour by a chilliness or even a rigor and a sharp rise lasting about half an hour. After this has passed off the patient feels and continues to feel remarkably well; no untoward symptoms of any kind have followed the rigors. A short attack of nephritis occurred in one patient, but this seems to have been occasioned by a chill. Pre-existing albuminuria of long standing was much reduced in one of my cases; in another the first injection succeeded in stopping a rebellious hæmoptysis.

*The Technique.*—The details of the operation are given in the paper. The injection consists of forty cubic centimetres of saline solution containing 1½ to 2½ grains protargol, and this is preceded and followed by an injection (through the same needle) of a few cubic centimetres of pure saline solution to obviate leakage of irritating fluid into the tissues, which is apt to lead to considerable pain and swelling. From twelve to fifteen injections generally suffice. It is best to administer them at intervals of one day, but in some cases they have been given daily.

*The Systematic Treatment.*—The protargol injection method has yielded by itself satisfactory results, but it does not claim to be more than the first and most important instalment in an extensive system of active treatment. My present practice is to combine with it, as soon as the case has lost all acuteness, general massage, gentle exercise, and particularly respiratory exercise for the expansion of the lung, strong diet and nutrient adjuncts, local and general treatment of the skin, and suitable internal remedies, among which I have obtained specially good results from ichthyol, originally recommended by Wertheimer. This combined treatment, a full description of which cannot be briefly given, has enabled some patients with originally un'favourable prognosis to become, after a few weeks' stay in the hospital, quite suitable for the open-air treatment, and to return, after a short period in the country, greatly improved, and with a promising forecast of ultimate recovery.

Drugs may have been too much discouraged owing to the superior virtues of "open air." Our knowledge of the latter should not paralyse, but stimulate our therapeutical activity. A place is still to be found for the old remedies, not any longer as the sum of our treatment, but as useful or necessary adjuncts. Expectorants, antipyretics, tonics, and sedatives may all have their temporary uses. But there are new remedies from which greater help may be derived, particularly when judiciously combined. Good combinations have been sacrificed to the desire to prove any one system to be a specific cure. The continuous inhalation of oxygen, for instance, is compatible with various hygienic helps, and with most useful forms of medication. The same is true of the hyper-nitrogenous alimentation advocated by Richet (raw meat treatment), and by Harper (urea treatment).

Wertheimer's ichthyol treatment consists in the administration after meals of a few drops of ichthyol, say, in peppermint water, with a daily increase of one minim till ten minims are taken—some of my

patients have taken twenty minims with advantage. A diminution in the cough and expectoration, and a change in the character of the sputum are perceptible in a few days. My own experience endorses Wertheimer's most encouraging reports, and for the present I have no hesitation in recommending ichthyol as the remedy which will most favourably and most rapidly influence the catarrhal complication, even when administered singly. But this or any other medicine found to be superior may be used in combination with intravenous injections; and it is my belief that such a combination would help us to effect a rapid change in the condition of the lung, and to subdue the catarrh sometimes within two to four weeks, and thus pave the way for a rapid improvement under the "open-air" treatment.

**Conclusions.**—In this system of treatment there is nothing final. On the contrary, all its details are provisional and merely the best that existing opportunities afford. Its results, hitherto, seem to justify a hope that yet better things are in store, and that well-sustained efforts in the direction indicated will, at no distant date, bring about a considerable reduction in the total duration of the cure of phthisis, and in the minimum period to be spent at Sanatoria.

The cases treated have all been hospital cases, and therefore illustrate the possibilities open to the State for the treatment of phthisis among the poor on a considerable scale, if Poor-law infirmaries and Sanatoria were thoroughly organised for carrying out a well-conceived systematic treatment. In all its details, and in special connection with the intravenous injections, the general scheme which has been proposed could be more easily conducted at public institutions than in private.

So long as no better remedies are forthcoming, those which have been suggested may be used with safety and profit; but it is urgent, in view of the important issues at stake, that a systematic inquiry should be undertaken into the comparative value of the various forms of treatment elaborated by individual efforts, and for some of which important claims have been advanced.

## THE PRINCIPLES OF TREATMENT OF TUBERCULOUS LARYNGITIS. (a)

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Royal Ear Hospital, London.

THE statistics of the pathological department of the Brompton Consumption Hospital show that the larynx is affected in over 50 per cent of the cases which succumb to pulmonary tuberculosis. As 70,000 persons die annually in the United Kingdom from this disease, at least 35,000 of them would have claimed our help in diminishing their sufferings from tuberculosis of the larynx. The statistics of averages warrant us in saying that there are in this country at least 75,000 who require our aid in arresting or easing the progress of tuberculosis of the larynx. The wide-spread character of this disease is therefore in itself a claim upon our attention; and when we remember the long drawn-out sufferings which may accompany it, and the youth of the majority of its victims, our humanity is keenly stimulated on their behalf.

The moment seems opportune for briefly reviewing the principles which may guide us in the treatment of tuberculosis of the larynx, for not only must we re-adjust older views to the modern light which has come

upon the scene, but such an occasion as the present congress rarely occurs for supplementing the experience of the laryngologist by that of the general physician and the pathologist. That this review is very necessary has been impressed upon me by the perusal of a large number of the most recent text-books on laryngology, few of which contain any reference to the treatment of laryngeal tuberculosis by modern hygienic methods. The frame of mind of many laryngologists is reflected in a recent paper by Dr. Johann Sendziak, in which he makes mention of the "rational—that is, the surgical—treatment" (a) of this disease, as if any method of treatment short of surgical was not worthy of being denominated as reasonable, and as if hygiene and rest were of no avail, and the *vis medicatrix nature* a myth.

Our principles of treatment are guided by clinical experience, but, when available, are based on pathological knowledge. The pathology of tuberculous laryngitis is rendered difficult by the complexity of the anatomical arrangement of the larynx. The varieties in the structure of the mucous membrane and sub mucosa, the functions it performs, the proximity of tendons, ligaments, muscles, cartilages and joints, the disposition of lymphatics and vessels, the occasional movements required in deglutition and the constant rhythmic action of the vocal cords in respiration, are all points which have to be taken into consideration. While the morbid histology of tuberculosis can be so readily studied in the larynx that Virchow recommended it as one of the best opportunities for observing the process, yet the complicated nature of the larynx renders an investigation of the anatomical conditions an equally important part of our task.

Tuberculous affections of the larynx have been classified under four categories:—

- (a) Superficial ulceration commencing from the surface;
- (b) Infiltration, followed by
- (c) Ulceration; and
- (d) Tumour formation, or tuberculoma.

This classification is of course somewhat arbitrary. It is seldom that two or more of these forms are not combined when a case first presents itself. As there is little doubt that in the large majority of cases infiltration precedes every other process, it is deserving of particular study as to its situation. It commences in the subepithelial layer, and when it takes place in regions where the mucous membrane is closely adherent to deeper tissue, and particularly to cartilage—as in the epiglottis, vocal processes, and arytenoids—it is very apt to spread to deeper parts, leading to perichondritis and necrosis of cartilage. Although the mucous membrane of the vocal cords is closely attached to the underlying tissue, the absence of subjacent cartilage renders infection of this part of the larynx a less rapidly destructive process. On the ventricular bands there is still less danger of immediate spread to adjacent cartilage.

Of all the various situations in the larynx the most frequently attacked is that of the arytenoids and the neighbouring inter-arytenoid space. Lake found this part affected twice as often as the vocal cords, and three times as often as the epiglottis and ventricular bands. (b)

In the early stages of such cases the vocal cords not only show a want of tension, but careful inspection will show that their movements are impaired both in adduction and abduction. This tendency to remain in the natural cadaveric position (i.e., the position of rest), the inter-arytenoid thickening, and the consequent dysphonia or aphonia, have inclined W. Fowler to look upon tuberculous laryngitis as chiefly a joint disease. He supports his view by the record of between forty or fifty autopsies of tuberculous laryngitis, and as his knowledge as a laryngologist helped to render these examinations very complete, I think the results deserve careful consideration. "In every case," he writes, "the greatest seat of the mischief was in the immediate neighbourhood of the crico-arytenoid joint, and the joint itself was

(a) Paper read before the British Congress on Tuberculosis, July, 1901.

(a) *Journal of Laryngology*, May, 1901.

(b) "Laryngeal Phthisis," London, 1901.

always implicated. The deepest part of the ulcer, when ulceration existed, was always immediately in front of the joint, and the joint not only communicated with the floor of the ulcer, but was also more or less disorganised. In many cases the arytenoid was a loose piece of dead cartilage." (a)

The pathology of laryngeal tuberculosis requires still further study, but in any case we seem warranted in assuming that, as in other parts of the body, the first process is one of infiltration. Universal clinical experience and pathological observations concur in establishing the fact that in a large majority of cases this infiltration first takes place in or about the arytenoid joints. Other parts are occasionally attacked primarily; the epiglottis less frequently than any other.

Leaving now for a moment the pathological aspect of the subject, let us consider it from the result of treatment. Writing in 1880, Morell Mackenzie observed, "It is not certain that any cases ever recover" (p. 383), and he states that he only knew of four in which he had reason to believe that the disease was entirely arrested. (b)

This view has been somewhat modified in the succeeding twenty-one years by the work of Moritz Schmidt, Krause, Heryng, and others. Their work has, unfortunately, diverted attention too exclusively to the possibility of exterminating the disease from the larynx by knife and caustic. Recoveries have, indeed, been claimed under various treatments, but we must remember that arrest will take place in the larynx as elsewhere without any local treatment whatever. When reaction and resistance of neighbouring tissues are sufficiently vigorous the advance of infection is checked by the fibroid change, which is the natural and desirable process of cure. In many cases the recovery is deceptive; partial cicatrization of an ulcer may take place in one part, or retrogression of an infiltration occur in the region visible in the mirror, while the process may be spreading in the depths of the tissues, or in such parts as the ventricles of Morgagni and the subglottic region. Besides, the foreshortened image we see in the mirror is a very unsatisfactory picture of the posterior laryngeal wall—the most important region in tuberculosis—and is always inadequate as regards the parts lying below the cords. Everyone who performs a laryngo-fissure, or opens a larynx on the post-mortem table, is prepared to find disease invariably more extensive than it appeared in the laryngoscope.

But what remains to us of all the various methods of local treatment which have from time to time been vaunted as curative of laryngeal tuberculosis? Their very number is eloquent of their inefficiency, and although some cases may have recovered under treatment, and many may have been locally relieved, yet we need hardly stop to consider whether the various sprays, pigments, insufflations, submucous injections, or intratracheal injections, had more than an alleviative effect, or whether, in the majority of cases, the irritation and reaction they produced did not far counterbalance any possibility of good.

None of the numerous methods which have from time to time secured some attention have ever appeared to me sufficiently rational to make them worthy of an extended trial. On the other hand, their disadvantages and uncertainties were only too apparent. I have, therefore, been compelled to appeal to the experience of others on this matter, and in doing so will only refer to what we may term the lactic acid and the surgical methods of treatment.

Applications of lactic acid to the tuberculous larynx have obtained such a vogue in the last ten or twelve years that the method has been applied *à tort et à travers*, practitioners in many cases persevering with it while the patient was being prevented, through its effects, from improving generally, or even steadily deteriorating in health. In many cases I have known of its being applied over unbroken mucous membrane,

covering deep infiltrations, or evident perichondritis, the surgeon apparently not stopping to ask himself how this superficial caustic could affect these deep processes, or do more than distress the patient and hurry on the progress of the disease. And now Freudenthal, who used it freely, states frankly that "it ought to be dispensed with as antiquated and barbarous torture of the patients." (a)

In 1899 Freudenthal subjected twenty-nine cases to surgical treatment without being able to record one single cure. (b) He then treated his cases of tuberculous laryngitis without curettage, and after a year's observations he wrote, "I believe my patients are just as well and perhaps better off than they would have been with the operation." (c)

The extensive and trustworthy experience of Jonathan Wright has led him to the following statement:—"The permanent radical cure of the local lesion of tuberculous laryngitis is not materially hastened by the various methods of treatment in any but an insignificant number of cases."

That a certain number of apparently permanent cures have been effected is undoubted. I have myself verified such a case both before and after treatment, which was shown by Dr. Lack to the Laryngological Society of London, (d), but the chief point to realise is that even the most enthusiastic supporters of surgical treatment of tuberculous laryngitis admit themselves that the majority of cases are unsuitable even for attempting operative measures. We must also remember that in this small minority of cases the method is painful and distressing; it cannot but react unfavourably on any general condition, and the result is extremely doubtful.

It seems to me that the treatment of the last decade has been based too exclusively on the bacillus as the one and only aetiological factor, and that due regard has not been given to more general considerations.

In indicating the slight and unsatisfactory results which have been gained from the direct treatment of laryngeal tuberculosis I must be understood as only deprecating much of the treatment in so far as it has been regarded as affecting a local cure. Where the progress of the disease—in the lungs and in the larynx—is not stimulated by local interference then many measures are available for symptomatic treatment, and we are well equipped nowadays for soothing laryngeal irritation and cough, easing pain, facilitating swallowing, and thus contributing to the general treatment and the possibility of cure.

We must look elsewhere at present than to surgical measures for a prospect of progress in the treatment of tuberculosis of the larynx. This progress is ready to hand in the making of an earlier diagnosis of local infection. The present is hardly the occasion, even if time permitted, for me to enlarge on the symptoms of the early diagnosis of laryngeal tuberculosis. Besides, the most detailed description of the laryngoscopic appearances could hardly portray a condition which would be recognised by any but an expert, so slight are the early changes, and so variously are they combined. "In general," says Grünwald, "it may be said that it is impossible to teach anyone theoretically how to make a diagnosis from the picture in any given case, because, in order to arrive at a decision, one must first learn the development of many successive pictures by long personal observation. Not the picture of to-day, but that of yesterday, and that of to-morrow, must decide for or against laryngeal tuberculosis." (a) But it is not only from the laryngoscopic appearances that a diagnosis of early local tuberculous infiltration, or of even pre-tuberculous laryngitis, can be made. We must make a careful and thorough examination of the entire body, and pay careful attention to such symptoms as anæmia, anorexia, dyspepsia, loss of weight and strength, hurried pulse, and evening rise of temperature. The previous history of the patient, particularly in regard to hæmoptysis and pleurisy, must be taken into consideration,

(a) *Journ. of the Amer. Med. Assoc.*, March 16th, 1901.

(b) *Philadelphia Med. Journ.*, March 25th, 1899.

(c) *Medical News*, New York, Jan. 19th, 1901.

(d) "Trans. Laryngol. Soc., London."

(a) "Intercolonial Medical Journal of Australasia," October 20th, 1896.

(b) "Diseases of the Throat and Nose," vol. 1, p. 383.

and the family history should not be forgotten. There are many other indications of early tuberculosis, and these, together with the indications for the employment of tuberculin as a diagnostic test, I must at present leave out of consideration. In this way evidence can often be obtained which will complete the diagnosis of a laryngeal condition which might otherwise be treated as a simple catarrh. In the absence of positive confirmatory symptoms, and of other adequate explanation of laryngeal symptoms, we must treat suspicious cases by measures that we know now will avert a condition which, once well established, is almost always incurable. In doing this we are but working along the lines and making the same plea for early diagnosis which has been so forcibly advanced in recent years in the subject of pulmonary tuberculosis.

Once the early diagnosis is made the treatment is exactly the same as that now employed in pulmonary phthisis—the sanatorium treatment in what should practically be the open air, with rest, hygienic surroundings, and good food. To this must be added, more or less, strict insistence on voice rest. This is found to be beneficial in many cases, even when the larynx is not affected. It must be much more so in laryngeal cases, when we realise that in the majority of instances the focus starts near or in the crico-arytenoid joints.

The treatment of catarrhal or obstructive affections of the nose and throat, and of any intercurrent conditions of the larynx, must, of course, receive careful and suitable treatment, and it is, therefore, very desirable that those in medical charge of sanatoria should be skilled in practical laryngoscopy. But the important principle to bear in mind is *primum non nocere*, for even a clumsy examination of the throat may produce more irritation and harm than any treatment can counterbalance.

Briefly recapitulated, the principles to bear in mind in tuberculosis of the larynx are as follows:—

1. Pathology and clinical experience show that in the majority of cases the focus of infection is near or in the crico-arytenoid joint.
2. Many cases only present themselves at a stage when the possibility of effecting a cure by local measures is quite untenable.
3. The principle of *primum non nocere* should be constantly kept before us, as many measures which have been tried in this affection have only distressed the patient and hastened the disease.
4. In the light of present knowledge and therapeutic resources, the most rational principle is to attempt to make an early diagnosis of the disease while in an incipient stage. Any persistent or suspicious laryngeal catarrh should be treated seriously on even a presumptive diagnosis.
5. Once diagnosed, the patient should be treated on the principles laid down in the modern method of sanatorium treatment.
6. Symptomatic treatment should be directed to any irritative, catarrhal, or obstructive condition of the air passages.
7. In addition, silence should be enjoined, the disuse of the voice being proportionate to the degree in which the focus of infiltration approaches or interferes with the arytenoid joint.
8. In cases where the situation or extent of disease do not warrant an expectation of complete arrest of the process, treatment should be symptomatic, and in many such cases the sanatorium treatment is uncalled for.

## Clinical Records.

### A UNIQUE CASE OF GENERAL EMPHYSEMA FOLLOWING TRACHEOTOMY.

By GEORGE FOY, F.R.C.S.,

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ONE of the least common of pathological conditions is general emphysema. Of the 43,610 wounds of the neck and thorax recorded in the *Federal Service* during the Civil War in America there was not a case, though there

were eight cases of partial emphysema. In the *Confederate States* there is not a case of general emphysema in the old *Medical and Surgical Journal*, though there are two cases of partial emphysema recorded. Heenan never came across one, neither did Guthrie. Longmore has not recorded one. Withal every military surgeon appears to expect it. Moulins, Wiseman, Cheselden, John Bell, Baron Larrey, the younger Larrey, and McGuire, who all have seen great numbers of throat and chest injuries, have but one case on record, the oft-quoted Larrey's light dragoon.

In civil practice a few cases are recorded. Wilks, in 1858, tells of a boy in whom a perforating ulcer of the trachea, occurring as complication of typhus, caused general emphysema. Somewhat similar is the Zenker and Grenosen case, in which an ulcer, of the size of a lentil, perforated the larynx, and gave rise to an emphysema that gradually during the course of some days became general. Schreger reports a case from fracture of the thyroid cartilage.

A unique case of the disease has, however, just been published by Dr. Ellett in the *Atlanta Journal Record of Medicine*. The patient, a boy, *æt.* 2, had his trachea opened for the removal of a foreign body—a watermelon seed. The incision extended from the bifurcation of the trachea to the larynx. The wound was closed with three layers of catgut sutures, one in the trachea, one in the muscles, and one in the skin and fascia, and the dressing applied. Following recovery from the anæsthetic the child began to cry, forcing air out of the tracheal wound, and thence along the layers of cervical fascia. The child swelled to an alarming degree, the emphysema being at first confined to the left side of the body and the right side of the head, but soon involved the subcutaneous tissue of neck, face, scalp, chest, abdomen, and scrotum.

The case was reported at the Memphis Medical Society in August, 1898, and in the discussion that followed Dr. Sale mentioned a somewhat similar case, in which partial emphysema, extending over the neck and chest developed as a complication after an operation.

The possibility of emphysema of the neck following on tracheotomy is referred to by Allen Burn.

But so far Dr. Ellett's case is the only one recorded I can find; it is the fifth case of general emphysema, and the only one occurring in so young a patient. During the Peninsular war prisoners on both sides, who were malingers to secure more comforts skilfully produced partial emphysema of the head and neck by perforating the tissues of the cheek from within the mouth to the cutaneous surface, and dilated the subcutaneous tissue by blowing through a fine cannula.

## Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, September 21st, 1901.

### HETOL IN LARYNGEAL AND PULMONARY TUBERCULOSIS.

A PAPER on this subject appears in the *Berl. Klin. Woch.*, 27/1901. The paper is really a report by Dr. Guttman on the subcutaneous use of the drug in the Polyclinic for nearly a year and a half. Referring first to the literature of the subject he remarks first that the majority of observers have noted improvement of the subjective symptoms soon after commencing the treatment. Both cough and expectoration were favourably influenced. Night sweats diminished or disappeared. The effect on the appetite was striking. The body weight increased in correspondence with this. No injurious bye-effects were observed. The treatment could be carried out on out-patients with moderate care. Cases were suitable for polyclinic treatment in which there was absence of fever, and the condition as to nutrition was moderate. Cases in which there was

(a) Grunwald on "Diseases of the Larynx," 1898.

lasting fever, quick decline, disturbance of bowels, and hæmoptysis were unsuitable for outdoor treatment.

In the Policlinic (Prof. Krause's) continuous observations were carried out, and the material employed was grouped in two series. The first series comprised twenty-eight cases, the whole of which at first appeared to Landerer himself as unfavourable. The period of treatment lasted from December, 1899, to August, 1900. The second series began in October, 1900, and lasted to April, 1901. In the majority of the cases there was laryngeal tuberculosis in addition to that of the lungs. The carrying out of the treatment was after the method proposed by Landerer. The solution used was a 1 per cent. solution of cinnamonic acid kept in coloured glass, kept clear in appearance, and either neutral or slightly alkaline. Before use it was sterilised by five minutes' immersion in boiling water. A properly-sterilised syringe was used. The needle was very sharp, so that a minimum of pain should be caused by the puncture. The needle and syringe were both kept in absolute alcohol, boiled before using, and washed out with sterilised 0.7 per cent. saline solution. Before making the injection an elastic ligature was placed on the left upper arm near the elbow. The region of the cephalic vein was then washed, first with ether and then with sublimate solution. After the air bubbles had all escaped from the syringe the needle was passed into the cephalic vein. The dose at commencement was half a milligramme of hetol. After the injection sterilised lint was placed over the site of puncture and fixed in position. According to the patient's condition the dose ranged from half a milligramme to eight milligrammes. The injection was repeated three times a week, the two arms alternately. The treatment was not continued in the presence of nephritis or diabetes.

Of the thirty-three cases treated, one recovered, ten improved, nine were treated without result, eight died, five withdrew themselves from treatment. The reporter designates hetol as a valuable remedy in the complaint, but denies that it is a specific, *i.e.*, that it possesses any antitoxic or bactericidal properties, but it has the property of supporting the organism, and in many cases may assist in bringing about a recovery. Care must be taken as to dosage. Large doses appear to be unnecessary. Taking the matter as a whole the reporter recommends the treatment in the early stages of the disease.

#### ALCOHOL AND TUBERCULOSIS.

The *Berlin Med. Wochen.* has an article on this subject by Dr. Hammer, of Brunn. From observation made on three cases the author is inclined to support the view of Koranyi to the effect that as in the liver and kidneys, in the lungs also an active development of connective tissue can be brought about by alcohol, which has the power of shutting off the diseased part from the surrounding healthy ones, and of thus leading to recovery. This observation was made in the case of three individuals who drank to excess, but whether similar results may be expected in other cases is not stated.

At the Niedersohen Gesellschaft für Natur and Heilkunde Prof. Schiefferdecker communicated a note on the

#### PRESERVATION OF BODIES BY CHINOSOL.

Completely satisfactory preservation could be effected

by 50 grms. of chinocol. The 50 grms. are dissolved in three litres of water, and after this is injected into the body, half a litre of water is added to assist in forcing the solution more effectively into the great vessels of the body generally. The injection is best made by means of an irrigator, and is very simple. The colour of the organs is in no way changed, both the blood and the muscles show their usual red colour. The brain, however, appears to take on a slightly yellow tint. By this injection both the bowels and the skin are efficiently disinfected and preserved. With the quantity used and equally distributed into all parts of the body each part will contain one per thousand or one per fourteen hundred, quite enough to kill off all fungi. It is also probable that infection from the body would no longer be possible. For disinfection of the hands a 1 in 500 solution is regularly used. When the body has to be kept for any length of time before being used it will be well to wrap it in cloths soaked in chinocol solution. Bodies which already smell badly when they arrive should first be washed with chinocol solution whereby the smell is much diminished. If bodies have already been opened cavities should be washed with the solution and cloths soaked in it should be allowed to remain in them.

## Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, September 21st, 1901.

#### ENURESIS IN CHILDREN.

THIEMECH gives it as his opinion that enuresis is not a symptom denoting a local disease, but rather a general neurosis resembling hysteria. His reason for coming to this conclusion is that most of the parents of such children suffer from a neuropathic disease of some kind, such as hysteria, &c. This may account for the epidemic form of enuresis that frequently attends our hospitals, which is often ascribed to other causes. Another ground for his belief in a neurosis is the ineffectual efforts of medicine to give speedy relief, enuresis being so obstinate to the potency of all medicaments to remove or alleviate the discomfort of the patient. The treatment that is most efficacious is that preferred in the restoration of the neurotic state, such as faradic treatment, injections of strychnine, &c. The suggestive treatment is not without its votaries, which also meets with a certain amount of success. The most powerful measure to adopt in the cure of enuresis is to remove it from the surroundings where the disease first commenced, or, more properly speaking, isolation.

#### GELATINE AS A HÆMOSTATIC.

Grunow's experiments still confirm the opinion that gelatine, when subcutaneously injected, is a powerful styptic. His injection is two grammes of gelatine in a hundred grammes of a physiological solution of common salt injected into the thigh, side of the thorax, or abdominal wall. This treatment has been in his hands most efficacious in many cases of internal hæmorrhage. The gelatine appears to rapidly act as a powerful agent in producing coagulation of the blood, and thus arresting the general diapedesis. There is one weak point in his experiments that militates against its success which he frankly admits. He tells us that some



of his cases required a combination of drugs to effect the hæmostatic action.

#### THE BAUSCHBRAND BACILLI.

Schattenfroh and Grasberger have for some time past been engaged in experimenting with the Bauschbrand bacilli, and conclude that they are genuine butyric acid producers in the presence of carbohydrates, and that sporification is carried on in the granular substance of the germ, although they acknowledge a double form of development by germination. The former have long, active flagellæ; the latter have none.

The cultivations exhibit both forms of generation; the chemistry and pathogenicity are unquestionable evidence of the presence of the microbe. Both generation forms are interchangeable.

#### CHANGES IN THE CENTRAL NERVE SYSTEM AFTER TYING THE THYROID VESSELS.

Muș in his experiment on dogs, tells us that there is a decided morbid change in the spinal cord, both longitudinally and transversely after tying the vessels of the thyroid, particularly in the posterior column, a less degree in the anterior column, as well as the posterior part of the lateral column. In the ganglionic cells of the gray substance as well as the spinal cells no morbid or degenerative changes can be observed. In the brain itself degenerated fibres can be found in the posterior bundles. In one dog, forty-eight days after tying the vessel, there was present a decided change in the pyramids extending from the pons to the cerebral convolutions. The longer the dogs lived after the operations the more decided the morbid changes.

#### DELIRIUM TREMENS.

Bonhoeffer, in discussing the complications in delirium tremens, thinks the first important change is acute congestion of the lungs and next of the stomach. Injury, direct or indirect, such as fatty emboli, is more imaginary than real, which may properly be said to hasten the pulmonary changes. The epileptic attacks may be properly relegated to a toxic source, and may be ascribed to excessive drinking and malnutrition.

#### PUERPERAL PSYCHOSIS.

Meyer, of Tubingen, records 1,104 cases of mental disease that have come into his clinic from 1894 to 1901, and finds that 51, or 4.5 per cent. became affected during the puerperal or lactation state. To be more accurate, 33, or 2.9 were affected during the puerperal period and 18 or 1.6 per cent. during lactation. Out of the 51 puerperal and lactation psychosis, 11 were of the melancholic type, 4 periodic melancholia, 3 circular psychosis, 5 were paranoic, 9 acute mania, 14 catatonia, 2 epiphrenia, 2 epileptic, and one suffered from hysterical psychosis. Meyer found nothing that would lead him to believe that there was any specificity in the ætiology of puerperal as such mental changes might occur under any other moments.

#### BIRTHDAYS.

Next month come two notable birthdays, for which great preparations are being made. The first is that of Virchow, æt. 80, of Berlin, on the 11th; the second is that of Professor Nothnagel, æt. 60. A committee, with Lorenz, Mannsberg, and Brewer at its head, has been appointed for the banquet-addresses which will be numerous and representative. A varied and international gathering is expected on October 15th.

## The Operating Theatres.

### WEST LONDON HOSPITAL.

**NEPHRECTOMY FOR HYDRONEPHROSIS FOLLOWING A NEPHROPEXY.**—Mr. SWINFORD EDWARDS operated upon a young woman, æt. 22, who had undergone fixation of the right kidney a month previously. This had been undertaken for what was evidently a luxated kidney, and which had troubled her off and on for years. Three days after this operation the patient complained of considerable pain in the abdomen. The temperature rose to 101°, and an area of dulness was discovered extending from the wound down to the iliac crest. After this, the temperature fell, and she experienced some relief. Ten days ago a rounded tumour could both be seen and felt in the right lumbar and iliac regions, which was dull to percussion, elastic to palpation, and a wave could be made out suggesting fluid contents. Hydronephrosis was diagnosed. The amount of urine passed had fallen from forty ounces before the operation to twenty or thereabouts. Mr. Edwards commenced the operation by excising the old scar. On cutting down into the kidney he came across several silk sutures, after the division of which a tense, elastic, bluish sac presented. This was incised and gave exit to quite a pint of urine. The kidney was next isolated, and the incision into what proved to be an enormously extended pelvis, was extended. The calyces and renal papillæ were now distinctly seen, but the ureteral opening was found with difficulty, being small and quite out of its usual position. Moreover, instead of being infundibuliform in shape it opened abruptly into the distended pelvis. A probe was passed with ease into the bladder. It was therefore evident that a kink into the ureter had caused the hydronephrosis, which kink was obliterated on drawing the kidney out on to the loin. The kidney substance lay altogether in front of the distended pelvis, and was thinned. The operator, thinking that mere drainage with refixation of the kidney would probably lead to a permanent urinary fistula, decided to remove the organ. This was accomplished by first dividing and ligaturing the ureter, the stump of which was carefully swabbed with carbolic acid. The remains of the pedicle were then transfixed with a blunt needle armed with silk somewhat thinner than is usually used, and tied with two interlocking loops. After excision of the kidney the branches of the renal vessels were tied separately on the distal side of the pedicle ligatures, and the operation completed in the usual manner, a drainage tube being inserted. Mr. Edwards remarked that hydronephrosis following nephrorrhaphy was not unknown, though he personally had not met with this accident in his series. He thought the cause of it might possibly be that surgeons were not sufficiently careful in replacing a loose kidney before anchoring it. It is, of course, a much easier proceeding to stitch a kidney to the muscles and fascia in the loin, *i.e.*, well below the last rib, than it is to stitch and maintain the organ in its proper position, which is with the upper half on a level with the lower two ribs. Mr. Edwards elected to remove the kidney on two grounds. First, on account of its attenuated and seemingly atrophied condition, and secondly because in these cases nephrotomy and drainage is apt to be followed by a permanent fistula for the cure of which

an ultimate nephrectomy would probably have to be undertaken.

#### ST. THOMAS'S HOSPITAL.

**EXCISION OF THE UPPER JAW.**—Mr. BATTLE operated on a married woman, *æt.* about 47, who had been sent to him for a tumour of the right nostril. The patient had noticed discomfort in the right nostril for about three months, and she had attended a special hospital for it. Here it was ascertained that she was suffering from a growth probably arising in the inferior turbinate bone. A portion of this was removed for examination, and proved to be carcinoma. On admission to St. Thomas's Hospital there was a tumour which blocked and distended the right side of the nostril and projected as a fleshy mass through the opening. The enlargement of the nostril extended up to, and indeed involved part of, the bony wall above. The nostril was completely blocked. There was some blood-stained discharge from the nostril, but no pain. There were no enlarged glands to be felt. The palate, the anterior wall of the antrum, the orbital plate, and the alveolar process appeared normal. There was no impairment of vision and no epiphora. The patient having agreed to the removal of the tumour, it was decided to take it away with the whole of the upper jaw, so as, if possible, to completely eradicate the site from which it was growing. The operation was done by Fergusson's method, and the whole of the upper jaw, including the orbital surface, removed. The incision was made through the centre of the upper lip, skirting the ala of the nose, along the side of the cheek to the inner angle of the orbit, and outwards along the lower margin of the orbit to the outer angle and for a short distance along the zygoma. The flap was reflected backwards, but in this case it was necessary to divide the nostril in order to permit of the better separation of the nose from the tumour; this incision on the nostril rendered complete removal much easier, but was not one, as Mr. Battle pointed out, that was frequently necessary, and should be avoided if possible. The bone was divided into the orbit by a keyhole saw in front of the attachment of the masseter muscle, and then from the nose into the orbit at the inner angle. The soft palate was separated from the hard, and an incision made through the mucous membrane of the hard palate forward to the socket of the incisor tooth. The saw was then placed in the right nostril, and the alveolar portion of the jaw divided in the same line as the incision in the mucous membrane. Bone forceps were inserted along the line made by the saw, and the separation completed. Lion forceps were then used, and the bone levered from its bed. It was found that the growth had not only invaded the anterior two thirds of the inferior turbinated bone, but had also spread upwards along the nasal duct almost to the canthus, and to quite the upper part of the nostril, so that it was surprising epiphora had not been a symptom. The curious point in the case, Mr. Battle said, was the presence of a growth, presenting a similar appearance, on the septum, opposite to the original tumour of the outer wall. The upper part of the growth had to be removed with a scraper as it could not be followed with a knife. The flap was sutured in position by means of multiple sutures of fish gut, and a plug placed in the cavity from which the jaw had been re-

moved. It was a matter for regret, Mr. Battle said, that the operation had not been performed directly after the growth had been diagnosed, but for some reason or another the patient was difficult to convince of the seriousness of her condition. Microscopical examination of the growth showed it to be colunar celled-carcinoma.

The patient suffered from a good deal of shock but recovered satisfactorily.

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### The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, SEPTEMBER 25, 1901.

#### THE TEACHING OF MATERIA MEDICA.

It may safely be said that medical education is still in its tentative stages, and that in spite of recent admirable advances there remains behind much that requires readjustment. The subject is certain sooner or later to arrive at a more perfect state of evolution, but that reflection should not hinder the attempt to hasten the day of salvation. Recent signs of the times tend to show that radical reforms are needed in medical training and examination. The high standard examinations demand a man crammed to the muzzle with a blunderbuss charge of details in every subject that enters into the curriculum. As a rule he is examined by men who are specialists in each branch, and who demand a detailed knowledge that would be more appropriate within the covers of a book of reference than as a fragment of the hastily-acquired and speedily forgotten information of the high standard student. As everyone knows, education may be regarded from two distinct points of view; first, that teaching which aims simply at developing the intellectual faculties, such as memory, reasoning, imagination, and observation; secondly, that which furnishes facts and knowledge necessary to the future career of the scholar. Medical education falls mainly within the second or technical category, although it is obviously impossible to dissociate the two by any absolute line of cleavage. It is difficult to say on what grounds it would be possible to

defend a vast deal that the student is forced to learn by the examiners, who practically pull the strings of medical education. Let the examiners say that a candidate must know the minutiae of some highly technical subject, say the electrical phenomena connected with muscular structures, and woe to the man who presents himself for examination without being fully charged with curious information upon the particular point in question, especially if one of the examiners happens to have hatched a pet theory of his own bearing in that direction. The fact of the matter is that both medical education and medical examination are left far too much in the hands of specialists. The value of minute and laborious research in the advance of science is vital to all progress, but the student is concerned more with essential principles and with a grasp of essential facts and a practical training that will enable him successfully to face the battle of professional after-life. *Materia medica* affords a concrete example of the useless lumber of knowledge that the student is obliged to take aboard. He has to acquaint himself with a vast mass of details as to the botany, chemistry, and physiological action of a myriad agents for which the ingenuity of man has found a place among medicaments. When the student becomes a practitioner he will confine himself to a score or so of drugs, and dismiss perhaps 95 per cent. of the remedies whose inner history and vaunted virtues he has so laboriously committed to memory. In *materia medica* a wise pruning of dry and withered branches would go far towards reviving the interest of medical men in what is still an important part of medical education. There can be little doubt that the advances of surgery and our more exact knowledge of the etiology and pathology of morbid processes have greatly lowered the relative importance of *materia medica* in the field of modern scientific medicine. Yet neither teachers nor examiners show any signs of relaxing their standards so far as the student is concerned. A short while since one of the leaders of the medical profession confessed in the columns of the *Times* that he had never heard of a drug which is found in the American Pharmacopœia. In a private capacity that lack of information was quite excusable, inasmuch as the virtues of the remedy in question appear to have no proved basis. At the same time it seems clear enough that a leader of the profession who enters into a public discussion in the columns of a lay newspaper should at least have taken the trouble to inform himself about the drug he was condemning. The fact that the drug figures in the American Pharmacopœia on the strength of empirical experience need cause no surprise. Our own Pharmacopœia presents a veritable chaos of unsupported theory and dogmatic assertion, which the student is nevertheless required to master before he can pass the ordeal of examination. The best man probably both to teach and to examine in *materia medica* would be a well-informed physician who is not a specialist in the subject.

By all means let us have our special researches by the best men obtainable and let them have ample means at command, but the exclusion of specialists at any rate from the examination table would probably inaugurate a sounder era in the teaching of *materia medica*, and, *ceteris paribus*, in other branches of the medical curriculum.

#### PERFORATION IN ENTERIC FEVER.

IN the zymotic death-rate of this country, at all events, enteric fever still holds a high place in spite of the improved methods of modern treatment. The fact that this mortality is due, not so much to the fever itself, as to the complications to which it is so peculiarly liable, makes the matter all the more difficult to deal with. Of all the complications perforation is that which is most feared, and one which until lately was almost always fatal. As Professor Osler, writing in the *St. Louis Medical and Surgical Journal*, says, "until within a comparatively few years in the presence of this disastrous event we folded our hands and murmured that all was over." That we should be forced to adopt this attitude in the presence of a complication which occurs in between four and five per cent. of all cases may well account for the high mortality, and it is most satisfactory to think that a new era has dawned, and no longer will it be necessary for the physician to stand passively by and await the death of his patient. If by the aid of surgery we are enabled to materially lessen the number of deaths from this grave accident, not only shall we have the satisfaction of considerably reducing the mortality of the disease as a whole, but we shall also save the lives of many who otherwise were doomed to a certain death. The figures which Professor Osler gives are certainly most encouraging. Up to January 1st of this year eleven cases of perforation had been operated on in his wards, five of which recovered, or 45.4 per cent.; five additional cases are recorded, one of which recovered, making a total of sixteen cases, with six recoveries, or a percentage of 37.5. In this as in all cases of perforation of the intestinal tract early diagnosis is essential to success, and on this subject Professor Osler has much to say that is both interesting and instructive. The time-honoured picture of perforation with the Hippocratic facies, the feeble running pulse, the profuse sweat, the distended motionless abdomen must be erased as a picture not of perforation but of peritonitis, or, as Professor Osler aptly calls it, "a rough draught of death." For surgical aid to be of use, and that it can be of use is shown by the figures quoted above, the diagnosis must be made before general peritonitis has developed, and thus it becomes the duty of every physician to study carefully the symptoms by which it may be recognised. The first essential is that every serious case should be carefully and constantly visited at short intervals by one who is competent to quickly grasp the changes in the patient's condition and who in such cases is hourly in collusion with

his surgical colleague. The complication occurs, as a rule, in severe cases and during the height of the disease, and those cases with diarrhoea and tympanites are more liable to this accident. As the majority of cases of enteric fever have no abdominal symptoms whatever it is not so difficult for the attendant to be on his guard. Professor Osler has drawn up a schedule of instructions which will well repay careful study. (1) Nurses must at once notify the physician of any complaint of abdominal pain by the patient, of hiccough or vomiting, of a special rise of pulse or respiration, of sweating, or of any signs of collapse. (2) The physician must note the character of the pain both as to onset and locality, particularly whether it is violent in paroxysms or merely an aggravation of the slight abdominal pain already present. (3) The condition of the abdomen both as to shape and the presence of respiratory movements. Percussion and palpation may also afford valuable information. (4) The condition of the patient as to the presence or not of sweating, vomiting, or hiccough, and any alteration in the facies, pulse, temperature and respiration must all be carefully noted. (5) In the majority of cases there is a marked and early rise in the leucocytosis present which should be looked for as it affords an important clue. The whole subject is one which demands the most careful study, a study too which can only be made at the bedside of enteric cases, making oneself familiar with the changes which take place in the course of the disease from day to day. When we think that out of a total of 20,000 cases of enteric fever which occurred in the Spanish American War only about 50 per cent. were diagnosed by the regimental or hospital surgeons, and that out of 25,000 cases in the South African War there was a mortality of 20 per cent., there is ample evidence of the necessity of a more careful study of the disease.

#### THE ABUSE OF SCIENTIFIC LITERATURE.

FOR some years past a wave, or rather a current, of scientific and medical literature has made itself manifest in the shape of a perfect deluge of books, to say nothing of repeated avalanches of more ephemeral literature, such as magazines devoted to one or other special department of science and medicine, monographs, transactions and proceedings of societies, and hospital reports. Personal vanity is unquestionably the most important factor in this exaggerated production. In spite of the ample opportunity for publicity afforded by the multiplicity of medical journals all over the world every medical society, be it never so provincial and never so insignificant, conceives a journal of its own to be indispensable to its corporate dignity, much to the disadvantage of its contributors whose papers are thus buried alive, reaching as they do but an infinitesimal number of readers. Even less useful are the ornate and costly reports which every hospital which respects itself inflicts upon medical humanity at stated intervals, instead of rendering

what is original and useful in their reports accessible to the professional public in journals of wide circulation. The difficulty of classifying and properly housing the ever increasing output of medical books is severely felt by those in charge of public libraries apart from the onerous requirements entailed in the matter of space accommodation. The mere indexing becomes a burden too grievous to be borne, and the copiousness of the indexes adds immensely to the task of reference. It is obvious that a very large proportion of the works which issue with unintermittent flow from the publishers' shelves are more or less identical in subject matter and treatment, and it goes for a good deal if the various authors not only duly acknowledge the source of their information but take the trouble to verify their references. One manifest drawback of this multiplicity of works is that the underlying facts, comparatively few in number, run the risk of being hidden in the mass of verbiage: in fact, one may well exclaim that "we cannot see the forest on account of the trees." Of late the United States has headed the list in this direction. The medical journals published in that land, flowing with ink and money, baffles enumeration. It is a noteworthy fact that whereas twenty years ago American works on medicine and surgery attracted little attention and commanded but a very limited sale on this side of the Atlantic, now they are to be found on the shelves of all medical libraries with any pretensions to comprehensiveness. The striking progress in medicine and surgery due to the originality and ingenuity of American physicians and surgeons fully explains and justifies this change of front, but it intensifies the plethora of the book market and adds to the burden of readers and librarians. It is idle to appeal to prospective authors to reduce their output to "the greatest possible minimum," as a contemporary expresses it. Their motives for writing are tangible enough to render them deaf to any such suggestion. Inasmuch as the writing of books and articles is the only form of self-advertisement open to medical men who respect professional ethics, they are not likely to forego so valuable a means of keeping their names before the public. Real honest literary work, the outcome of prolonged observation and attentive study, will always be welcome, but to what a very small proportion of the works which throng the reviewer's table can this description be conscientiously applied?

#### Notes on Current Topics.

##### Empyema of the Antrum of Highmore in Infants.

THE antrum of Highmore attracts the interest of specialists in many different lines of medical science and practice. Anatomists, surgeons, dentists, ophthalmologists, rhinologists, physicians in fever practice, and others. Anatomical descriptions of its formation seem to leave much to be desired; it appears, however, to be pretty well established that

the cavity of the antrum exists at a much earlier date than was at one time believed. It is not easy to understand the difficulty felt by some in accepting the diagnosis in most of the published cases of empyema of the antrum in young infants. There have been but few such cases published, and it has been held by Avellis that the condition was really one of necrosis of the superior maxillary bone. Dr. Emil Mayer, of New York, in the *Medical Record* for August 10th, records a case which came under his care, of a female child, aged 2½ years, which was brought to him in consequence of a fistulous opening having developed in the right cheek from which pus exuded. An eversion of the lower lid and fœtor from the nostril were also present. The previous history was to the effect that the child six weeks before had been attacked with scarlet fever, with pneumonia, and, shortly afterwards, diphtheria, principally nasal, had appeared. Careful examination led Dr. Mayer to the conclusion that the condition present was empyema of the antrum of Highmore. A case of Dr. Platts, of Baltimore, is given *in extenso*, in which the infant was only five months old. Pus was discharged, not only through a sinus on the cheek below the orbital margin, but also through a sinus opening on the gum "in the region of the second molar tooth," from which a rudimentary tooth was removed. Infection with gonorrhœal pus was believed to have taken place during birth, but why this opinion was formed does not seem clear from the report. The first case on record is more remarkable still. It was that of an infant, aged two weeks, reported by G. A. Rees in 1847. The eyeball was protruded to such an extent that the lids could not be closed; the palate was depressed and the cheek prominent. One of the rudimentary molar teeth being apparent was extracted, and a director passed easily into the antrum and allowed the escape of a "considerable quantity of thick matter." On the next day an abscess near the inner canthus was opened, and water injected into the antrum from below came out on the cheek. Rees believed that the pressure of the arch of the pubes on the cheek caused the mischief. Other cases are quoted by Dr. Mayer and commented on, and points in dispute are ably discussed. Perhaps most interesting of all is the consideration of the infection of the antrum in infectious diseases. From the evidence produced of the pathological conditions frequently found in the antra in fatal cases it is reasonable to believe that infection commonly occurs also in cases which recover.

#### Blue Electric Light.

VERY extensive therapeutic effects are to be derived from the use of blue electric light, and if the favourable experiences recorded by Dr. A. V. Minine in *Fratch* of June 23rd are confirmed by subsequent investigations, a great advance in the art of healing has been made. Dr. Minine has found that while blue light produces an anæmia in the parts exposed to it, white light causes the tissues to be filled

with blood. The chief advantage claimed for blue electric light lies in its action on the vaso-motor nerves. A further benefit to be secured by the use of this blue light is that it has a very marked anæsthetic effect, and Dr. Minine has employed it in the suturing of wounds instead of cocaine. Burns and scalds heal rapidly and painlessly without any local application being necessary under the influence of this new method of treatment. It appears that the removal of stitches can be carried out without causing any pain by utilising the action of this light. In purpuric patients it is claimed that the general condition of the patient, the appetite and the sleep are greatly improved. If a contusion be exposed to this light the occurrence of ecchymosis or of a hæmatoma is thereby prevented. In the history of medicine it is not unknown that the advocates of particular methods have in perfect good faith claimed more for their therapeutic measures than has afterwards been found to be the case. But if only a portion of the favourable results recorded as ensuing from the use of the blue electric light are capable of being utilised by the ordinary practitioner, the treatment of many puzzling conditions will be greatly simplified.

#### Magistrates and Conscientious Objectors.

THE spectre of the conscientious objector appears to deprive magistrates of their common sense in some instances, witness the strange case which was recently adjudicated upon at the Thorpe Police Court. The *soi disant* conscientious objector alleged, as the ground of his conviction, that his mother had died "after vaccination," and on this he based his claim of exemption for his child. It was pointed out to the bench that the lady in question had been vaccinated when a baby and had lived to be a grandmother, yet the plea was favourably entertained and the objector obtained his exemption. Some one might have pointed out to these sapient justices that if one does not die before vaccination one must perforce die after, death being an hereditary complaint.

#### The White Cross League.

THE education of the public in regard to sexual matters is admittedly one of the crying necessities of our epoch. Incalculable harm is wrought by ignorance, which passes for innocence, on this subject, and the White Cross League is unquestionably rendering a public service by placing at the disposal of those who are willing to learn, such advice as is contained in the pamphlet just issued on "The Duties and Responsibilities of Married Men." The married state is regarded by many as an authority for unlimited self-indulgence, the results whereof are detrimental not only to the parties immediately concerned, but also to generations as yet unborn. It is well that married people should be made to understand that marriage has its duties and its restrictions, as well as its privileges. The pamphlet is virtually an amplification of the sage precepts embodied in the marriage service. It points out marriage affords

unparalleled opportunities for self-control and self-discipline, the sacrifice of which entails a lowering of the moral fibre and the risk of much physical and social unhappiness. Incidentally it teaches the lesson that although procreation is the object and aim of marriage, this function, like all others, ought only to be exercised within certain limits. The health of the mother and the physical well-being of the offspring impose certain limits which prudent parents will observe. The regulation of the sexual appetite, especially by the married, is a high ideal, an ideal to which possibly few may aspire with confidence, but in this respect the teachings of theologians and physiologists are in accord.

#### Small-pox in London.

RECENT correspondence in the daily press confirms our contention that some systematic control in respect of vaccination over children attending elementary schools should be put in force. The Rev. J. J. Coxhead, in a letter to the *Times*, states that forty out of 170 school children had not been vaccinated at all, and the closure of the schools simply means that for six weeks to come 700 children will be running about the streets. Incidentally this correspondent mentions that there are, in the district of St. Pancras, which has an unfortunate reputation for indifference to sanitary precautions, "houses badly drained, uncleanly, with underground kitchens inhabited in contravention of the law" to which he has repeatedly called the attention of the sanitary authorities, apparently in vain. Under these circumstances it can be no matter for surprise should small-pox attain the dimensions of a formidable epidemic, and we can only hope that the School Board authorities will take such steps as are in their power to check its spread. To ensure the protection of the inflammable material in their schools is a step of vastly greater importance than merely closing the schools in the affected districts, since the latter leaves the children ready victims to infection. There is nothing, so far, to justify serious apprehension, the increase in the number of patients under treatment being only what one must expect under the circumstances, but since there is abundant evidence to prove that small-pox cannot obtain a foothold in any well-vaccinated community, it is urgent to adopt measures having for object to protect the community against anything in the nature of a widespread epidemic.

#### The Medical Officership of Health at Southampton.

THE good folk of Southampton have had a smart family squabble over the appointment of a new medical officer of health. The combined salary of that and other posts reached £500 per annum, with a yearly tenure of office. There were thirteen candidates, and disappointment was expressed in the council chamber that a larger number had not been forthcoming. Three candidates were chosen by the Sanitary Committee, namely, the gentleman who for the last three months had acted as assistant medical officer at Southampton; a medical man who has

practised in the town for the last eight and a half years; and the assistant medical officer of Leyton. The second of these gentlemen was selected by a large majority. He had, until recently, been a member of the Town Council, and it was stated that a number of votes had already been pledged in his favour. To that local influence and to the smallness of the salary one of the speakers, Dr. Eliot, attributed the fact that the list of applicants was unsatisfactory both in quantity and quality. How any town council can expect to secure the exclusive services of a first-rate medical officer of health for such a salary is beyond conception. How is he to live and maintain a family upon such a salary in a manner befitting the importance of his position, not to mention the insecurity of tenure? In many respects the officership of a great port like Southampton is one of the most important in the United Kingdom. It is to be hoped that the municipality will sooner or later rise to a sense of the responsibilities and the needs of the situation, and will materially increase the salary offered to their medical officer of health, while they at the same time do away with the faintest suspicion of parochial jobbery.

#### Scarlet Fever in the Midlands.

BIRMINGHAM is increasing its hospital accommodation for scarlet fever, in view of the gradually extending epidemic. Last week there were 471 patients under treatment in hospital, as compared with 456 in the preceding week, and 324 in the corresponding week of last year. These figures had not been reached during the past five years, and one most unpromising feature is that the seasonal maximum is not due to arrive until November, so that there appears to be good ground for the fear of the local authorities that the worst period of the epidemic is yet to come. In a densely crowded industrial population like that of Birmingham the control of communicable diseases presents a problem of peculiar difficulty. So far as the isolation hospitals are concerned it is interesting to note the popular prejudice runs altogether in favour of those institutions. In these days of rapid and free international transit an infectious outbreak in a great town has a bearing on the whole community. It has been shown again and again that epidemics of enteric fever, small-pox, cholera, and other specific infective diseases have been started in whole districts by the advent of a person hailing from an infected town. There were twenty-eight cases reported last week in Birmingham from enteric fever, a number that is surely too large in view of our modern knowledge of the origin of that disease. There are also about fifty or sixty deaths weekly from diarrhoea, another preventible malady.

THE "Transactions" of the Thirteenth International Congress of Medicine have just been issued, and members who have not received copies thereof are requested to apply to the Editors, 120, Boulevard St. Germain, Paris, before December 31st.

### Medico-Literary Advice.

AN American contemporary relates the story of a certain novelist who called in his family physician to assist him in disposing of one of his superfluous characters. Much to his surprise he was favoured by and by with a bill for services rendered, which he naively admitted appeared to him "somewhat extraordinary." It says little for the author's perspicacity that he should have failed to recognise the value of the advice. We can call to mind quite a number of romances which would have gained hugely in likeliness had their writers taken the trouble to get their medical advisers to supervise the symptomatology. We should not hear of heroes being reassured by feeling the pulsation returning in the heroine's femoral artery, rascals would cease to throw their victims abruptly into unconsciousness by waving a handkerchief soaked in chloroform before their faces for a brief fraction of a minute, and many diseases would run a course more in accordance with text-book descriptions than is at present the case. We can imagine that Rudyard Kipling, in "The Light that Failed," must have enlisted the criticisms of a man skilled in ophthalmological work, for his description of the onset of optic atrophy is as good as a clinical lecture.

### Public Baths and Eye Affections.

RESORT to public swimming baths is a not unlikely source of infection in various ways, and it is stated that in Philadelphia numerous cases of eye disease, presumably of the nature of ophthalmia, are under treatment at the hospitals as a result of this practice. It is not so much the management of the particular baths as the system itself which is at fault, for although great care is taken to secure an ample supply of fresh water, contamination by a large number of bathers is inevitable. The remedy suggested is the substitution of shower baths for swimming pools, and the most recently built bath there has been constructed on this plan.

### The North India School of Medicine for Women.

WE have received an appeal on behalf of the Ludhiana Hospital and Medical School for funds to enable this institution to provide an adequate teaching staff and laboratories with the object of affiliation to the University of Lahore. The students will then be eligible for university degrees in medicine which will enable them to treat the native women who are debarred by religious scruples from accepting the ministrations of doctors of the opposite sex. There is a great dearth of native girls of good family to fill the posts of house surgeons, anaesthetists, and nurses, and the object in view is to open the portals of the profession to such students. The school is already recognised by government, and is in a position to secure a sufficient number of students. We note, not altogether with approval, that "besides alleviating bodily suffering it may reasonably be hoped that the influence of

the medical students will aid the progress of Christianity in India." We hold very strongly to the opinion that medical work should not be made a means of proselytism. The knowledge that these students are virtually missionaries as well as doctors cannot but prejudice the natives against them. Let them preach the Christian virtues by example by all means, but the operating theatre and the sick bed are not, in our opinion, sites of election for dogmatic instruction.

### The Effect of Heat on Blood Stains.

WE referred some time since to the method devised by Wassermann and Schutze for the identification of the origin of blood stains, a method which enables us to ascertain conclusively the source of the blood in a given case, a discovery the importance of which in medico-legal work is obvious. It remained to be seen whether the value of this discovery might not be impaired by accidental circumstances, such for instance as the action of heat. An Italian observer has instituted a series of experiments in which blood was submitted to the action of heat before being tested, and he found that blood which had been exposed to a temperature of 130° C for an hour, or a less period in proportion to the rise of temperature, failed to give the characteristic serum reaction. The formation of hæmin crystals, however, is not prevented by these temperatures, so that, though the sanguineous origin of a given stain may be proved by the formation of these crystals, the specimen may not give a precipitate with the serum of an animal immunised by the blood of the species from which the blood stain is derived. The action of heat may be suspected by the changes which blood-stains undergo in this event, viz, the diminished solubility, their lighter colour, and the special form of the hæmin crystals. This observer also calls attention to the fact that the serum of an immunised animal loses its properties in the course of a fortnight or thereabouts, so that it is essential to make use of a fresh serum in carrying out these experiments.

### The Influence of Spices on the Stomach.

ALTHOUGH the use of spices for the purpose of heightening the flavour of food is almost universal, it is generally recognised that their influence on digestion is detrimental, hence dyspeptics are warned to avoid "spiced and made dishes." Some experiments recently carried out by a Polish physician, Dr. Korczynski, tend to prove that while spices stimulate the motor function of the stomach, they progressively impair the secretory functions, and, in the long run, inhibit the production of hydrochloric acid. On the whole, therefore, the ingestion of spices hinders, rather than accelerates, digestion, though an exception may be made in respect of persons in whom slowness of digestion is due to a deficiency of muscular activity on the part of the stomach, and also possibly of the victims of hyperacidity. Opiates, as is well known, tend to increase the acidity of the gastric

juice, hence they are contra-indicated in cases of hyperacidity, and alkalis merely neutralise the excess of acid without benefiting the disordered function to which the excess is due. It may be inferred that for persons whose digestion is normal the employment of sauces and spices is undesirable. A witty Frenchman once described Worcester Sauce as an English device for giving the same taste to all kinds of meat, and there is no doubt that the habit of tickling the palate by the addition of various condiments is one to be deprecated.

#### Micro-organisms in Growing Vegetables.

GROWING vegetables absorb the inorganic constituents of the soil and convert them into organic compounds. This process of plant-digestion of course takes time, and it follows that until the vegetable cells have been enabled to carry out the transformation, the contents of the vessels retain whatever pathogenic properties the original soil possessed. Along with the inorganic constituents of the soil various micro-organisms find their way into the plant, and repeated bacteriological investigation has proved that certain of these organisms may, and do, retain their virulence. These results are confirmed by a series of experiments recently made public by Wurtz and Bourges who found that typhoid and anthrax bacilli could be recovered in the leaves for three weeks after the inauguration of the experiments. These facts have an important bearing on the importance of cultivating vegetables intended for food as far as possible on a pure soil. This is specially important in respect of vegetables of a kind usually eaten raw grown on sewage farms, indeed, pending careful observation of the bacteriology of plant-growth under these conditions it would appear desirable to avoid the cultivation thereon of salad plants and of all vegetables to be consumed raw.

#### The Dangerous Zone for Intragluteal Injections.

SENSORY and motor disturbances have been observed to follow mercurial injections made in too close proximity to the sciatic nerve, effects which have, reasonably enough, been attributed to the inflammatory reaction in the nerve trunk excited by the presence of the mercurial salt. The "dangerous zone" may be outlined by drawing a line passing two fingers' breadth outside the posterior superior iliac spine, terminating at the point of intersection of the gluteal fold and the central line of the posterior aspect of the thigh. The region to be avoided is contained within lines drawn parallel to the above at a distance of an inch and a quarter on either side, between the posterior superior spine above and the gluteal fold below. In making the injections it is desirable to direct the point of the needle away from this zone. The safest spots in which to make the injections are the retrotrochanteric area or at the intersection of a horizontal line passing two fingers' breadth above the great trochanter and a vertical line passing from the junction of the internal and middle thirds of the buttock.

#### The Local Government Board and Vaccination Prosecutions.

THE Local Government Board has caused to be forwarded to boards of guardians a circular dealing with certain questions which have recently arisen under the Vaccination Acts, 1867 to 1901, in connection with proceedings taken with a view to procuring an order for the vaccination of a child under section 31. It is laid down that notices may be served by prepaid letter, without registration, and that such notices need not be served personally upon the parent or other person in charge of the child. Proceedings under section 31 of the 1867 Act do not necessitate proof that the public vaccinator has given notice of his intention to vaccinate the child, or that he has actually visited the child's home for that purpose. The actual notice need not be produced, nor a copy thereof, verbal evidence of its contents being sufficient, but vaccination officers are nevertheless advised either to use printed forms or to keep a carbon duplicate of the notice for production at the hearing.

#### The Magnet as a Means of Removing Metallic Foreign Bodies from the Eye.

THE value of the magnet in removing splinters of iron from the eye is now fully recognised, but the extraordinary strength of certain electro-magnets recently devised has in some cases proved to be a cause of additional injury. In some cases reported by Dr. Holström the attractive force of the instrument was such that the splinter was dragged out with so much violence as to determine further serious injury on its path. He infers from his experience that a very powerful electro-magnet is an instrument to be used with prudence, and he finds it preferable in many cases to draw the foreign body into the anterior chamber by the aid of Haab's powerful instrument, completing its removal with one of less strength.

#### Cedron Seed.

AN official report dealing with Jiminez, Costa Rica, contains an interesting announcement from Dr. S. H. Hodgson, the Government physician stationed at that place. His attention was drawn to the remarkable antitoxic properties possessed by the tincture of "cedron seed." This tincture is in use in certain parts of Central and South America as an antidote for snake bites and for the stings of venomous insects of various kinds. It occurred to Dr. Hodgson to try the effect of cedron seed in the treatment of yellow fever, and after observing the results of its administration in a number of cases he arrived at the conclusion that it has as specific an action in yellow fever as quinine has in malaria. Every case that was treated with the tincture recovered, and the method of its exhibition was by hypodermic injection of twenty minims three times a day. The immediate improvement that ensued was most noteworthy, the headache was relieved and the nausea subsided, whilst in cases in which the injections were commenced early the congestive phenomena were very slight. Considering that these very promising



results were obtained by Dr. Hodgson under the most unfavourable circumstances, the report would appear to furnish grounds for believing that the investigation is one worthy of being followed up. The patients were native labourers on the country farms, and they were nursed under the most unfavourable and insanitary surroundings. The only nurses available were dirty, ignorant natives absolutely devoid of the most elementary ideas of what was required, and the tincture was home-made, by no means guaranteed to be antiseptic, and of very uncertain strength. Any advance in the therapeutical treatment of such a fatal malady as yellow fever is sure to be received with gratitude by those whose duty it is to deal with this insidious foe, and we can only hope that the happy experiences of Dr. Hodgson will be confirmed in the practice of other physicians.

#### Phototherapeutics.

ONE result of the great success achieved by Professor Finsen, of Copenhagen, in the treatment of lupus by means of rays from the ordinary arc light has been to stimulate scientific inquiry in the direction of phototherapy, and it is now stated that Dr. Sophus Bang, one of Professor Finsen's assistants, has devised a new lamp which possesses ten times greater bactericidal power than the ordinary arc lamp. The special electric lamp invented by Dr. Bang is reported to possess but feeble illuminating powers, but for phototherapeutic purposes it is extremely active, owing to its richness in actinic rays, the poles being made of metal instead of carbon. An important consideration in respect of Dr. Bang's apparatus, from the point of view of expense, is that it effects a great economy, a fact that will enable this remedial measure to be more generally employed. In connection with the question of the expense of working the Finsen apparatus, and the cost of the necessary nurses, Dr. Garston has lately described in certain French medical journals an ingenious and inexpensive apparatus, manufactured for him by MM. Lortet and Genoud, of Lyons, which simplifies very much the application of Finsen's method of treatment. Briefly described, the advantages claimed are the use of a lamp of lower voltage, the reduction in the time of exposure, the increase of the surface area affected, and the saving of a great amount of electric current. A distinctive feature in this apparatus is the arrangement for focussing the rays; this is made up of two rock crystal lens, separated by a current of running water.

#### Leprosy.

IN the recently-published international periodical, entitled *Leprosy*, it is stated, on the authority of Ehlers, that the Guber springs, in Bosnia, have an unmistakable curative influence on leprosy. These springs, we are informed, have been credited from time immemorial with healing powers of the kind suggested, and it is satisfactory to find that after a

very full and complete examination by Ehlers, he declares himself "amazed and delighted" at the successful results he has himself seen and studied. This favourable report is fully borne out by the independent researches of Professor Glueck, whose experience covers a series of cases that have been cured at the Guber springs. It has, of course, been long recognised that in certain conditions of leprosy a permanent cure is not impossible, but it is nevertheless exceptional, to say the least, to have definite medical testimony that under a course of Guber waters, internal and external, leprosy ulcers heal with subsidence of the nodules and other objective and subjective symptoms. The only weak point in this otherwise pleasing report is that the permanency of the results in the cases described as cured is not very accurately determined in the accounts so far to hand.

#### Anal Pruritus.

THE treatment of cases of that refractory condition, anal pruritus, generally taxes the patience alike of the sufferer and of his medical attendant, and it is worth noting that Dr. Siebourg (*Centralblatt f. Gyn.*, June 27th, 1901), of Bremen, reports great success in the relief of obstinate cases from the use of local subcutaneous injections of a very dilute solution of carbolic acid. From the description given it would not seem to matter much what the exact nature of the fluid is, the important factor appears to be that the injection must be in sufficient quantity to lift the skin, and to cause sufficient traction on the nerve terminals to bring about numbness to the extent of abolishing the pruritus. This gratifying condition of ease is said to last for a week or longer, thus giving time for other local treatment.

#### An Ophthalmological Curiosity.

THE following exceptional incident is described by Dr. Strawbridge in the *Archives of Ophthalmology* as having occurred in the course of his examination of the right eye of a patient who had received a blow on the right temporal region; the lids were very gently opened, when, to the astonishment of Dr. Strawbridge, the eye suddenly slipped out of its orbit and remained fast in this position with the lids in close apposition behind. This extraordinary dislocation was reduced by steady pressure, the lids being held apart, the return of the organ into its place being marked by a distinct click. A few days afterwards the eye was carefully examined and found to be normal and free from symptoms of irritation.

#### Medical Regulation of Marriage.

A BILL to regulate marriage is now under discussion in the State of Colorado. The proposed regulation is to render it impossible for any couple to be united in holy matrimony until the candidates have been duly passed by a board of medical examiners as mentally sound and free from the taint of tuberculosis, cancer, syphilis, and other diseases. The punishment for daring to be married without under-

going medical examination is described rather vaguely as "heavy penalties," and they will have to be very heavy indeed to enable such a law to become really operative. The Bill apparently enforces this examination on women as well as men, and this under present conditions is likely to render well nigh insuperable the already grave difficulty of working such an Act.

#### The Treatment of Epilepsy.

A SUGGESTION is made by Balint (*Berlin Klin. Woch.*, June 10, 1901), to replace sodium chloride in the diet of the epileptic by a bromine salt. This method is to be thoroughly carried out, and it is recommended that bread for the use of epileptic patients should be made with a bromine salt instead of sodium chloride. The first objection that is naturally raised against this plan of Balint is that bromism must surely result, but it is stated that this was not observed in any of his twenty-eight cases. This is a complete answer so far as it goes, but the number is too small to justify us basing any absolute conclusion. Certainly the plan seems a very agreeable way of administering bromide. A fair share of credit in the success observed in the twenty-eight cases should no doubt be ascribed to the increasing amount of bromide administered. The treatment has been found in practice to require its being carried out in a suitable institution, and this must unfortunately decrease its value. A really satisfactory solution of the treatment of the epileptic at home has yet to be found.

#### A New Tract in the Cord.

DR. PURVES STEWART, of the Westminster Hospital, has discovered a new tract in the spinal cord. It is a descending tract in the cervical region, situated ventro-externally to the crossed pyramidal tract and separated from the latter by a distinct interval at a plane corresponding to the tip of the lateral horn of the gray matter. It does not extend below the level of the eighth cervical segment, and somewhat resembles in shape, but differs in position, from the tract described by Helweg and v. Bechterew. It was first made out in a patient at the Westminster Hospital who sustained a dislocation of the vertebral column between the bodies of the fifth and sixth cervical vertebrae, crushing the spinal cord at the upper part of the seventh segment for a vertical extent of about half-an-inch. The patient, it is interesting to note, survived for ten weeks after the injury. The new Purves-Stewart tract is exciting much attention, especially among German neuropathologists.

#### Pulverised Bone Ash.

THE injection of pulverised bone ash prepared from the femur of a steer, in distilled water and gum, has been used for the purpose of procuring union in a case of ununited fracture of the ulna and radius in a robust adult suffering from delirium tremens. The bone ash in gum water to the amount of 10 c.c. was injected every four weeks. When this treat-

ment was commenced no callus at all had been formed, but after the sixth injection union of a firm and lasting character was obtained. (*Centralblatt. f. Chir.* June 29, 1901.) It is stated that the reason for not submitting the man to a surgical operation of some magnitude was that the restlessness associated with his condition precluded this being done.

#### PERSONAL.

COLONEL A. B. R. MYERS will take the chair at the annual dinner of past and present students of St. Mary's Hospital, at the Whitehall Rooms, Hotel Metropole, on the 3rd prox.

MR. CHARLES STONHAM is to preside at the annual dinner of past and present students of the Westminster Hospital, which is announced to take place on October 4th at the Hotel Cecil.

MR. ALFRED COOPER, F.R.C.S., President-Elect of the West London-Medico Chirurgical Society, will open the Winter Session on Friday evening in next week with an Inaugural Address.

DR. HUGHES, of Llanilar, Aberystwith, has been presented with a valuable cabinet of silver, containing upwards of two hundred pieces, on the occasion of his retiring from practice.

OUR Vienna correspondent refers in another column to the preparations being made to celebrate next month the eightieth birthday of Professor Virchow and the sixtieth of Professor Nothnagel. Long may these brilliant stars illumine the medical firmament for the behoof of mankind.

DR. DUTTON, Principal of the Fifth Malarial Expedition sent out by the Liverpool School of Tropical Medicine, left Liverpool on Saturday last, with his party in the mail steamer *Arim* for the West Coast of Africa, where every assistance is offered the expedition by the Governor of Gambia, Sir George Denton.

WE understand that Dr. Yellowlees has already resigned, or is about to resign, the important and lucrative post of medical superintendent to the Gartnavel Asylum, Glasgow, which he has held for a great number of years in connection with the Lectureship on Insanity at the University of Glasgow. There are expected to be a considerable number of candidates for the vacancy.

#### Scotland.

[FROM OUR OWN CORRESPONDENT.]

THE BRITISH ASSOCIATION FOR THE ADVANCEMENT OF SCIENCE.—Glasgow has been honoured with the presence of the members of the British Association, to the number of nearly 2,000, during the past week. The meetings have been held in the University, which served the purpose most admirably, the various class-rooms being used for the sectional meetings. Many members of the medical profession have attended the meetings, and a goodly number read papers of considerable interest to the profession. Prof. McKendrick, as President of the Physiological Section, delivered an address on the advances in physiology during the last twenty-five years. Papers were read on "The Use of the Telephone for investigating the Rhythmic Pheno-

mena of Muscles," by Prof. Sir J. Burdon-Sanderson; "Experiments on the Brain of the Ape," by Prof. Sherrington; and Dr. Robert Kennedy read an interesting paper "On the Restoration of Voluntary Movements after Alteration of the Nerve Supply by Nerve-crossing or Anastomosis." Papers were also read by Prof. Cleland, Glasgow; Dr. Sutherland, Deputy Commissioner in Lunacy, Scotland; Dr. J. F. Gemmell, Glasgow, and others. Prof. Sims Woodhead, Cambridge, who was also attending the meetings, gave an address, on the 19th inst., in connection with the meetings of the International Assembly, which held their meetings in the lecture-room of the Art Galleries. His address was a very interesting one on preventable diseases. By means of the lantern he showed the micro-organisms of a number of diseases, such as diphtheria, cholera, plague, tetanus, &c., pointing out the distinguishing features of each. The address was much appreciated by those present.

THE NEW ANATOMICAL SCHOOLS, GLASGOW UNIVERSITY.—Glasgow University can now boast of having a well-equipped anatomical department. Instead of the galvanised iron sheds which were such an eyesore for a number of years, standing as they did in front of the University in a very conspicuous position, there are the new and handsome buildings which have just been finished, thanks to the generosity of the trustees of the late Mr. Thomson, shipbuilder. The buildings are very complete and offer every facility for teachers and students engaging in their work profitably and at the same time very comfortably. At the opening ceremony, which was largely attended, Professor Cleland took the opportunity which presented of magnanimously handing over to the University for all time his large and varied collection of anatomical preparations, for which he was heartily thanked. Lord Lister, Sir William Turner, Principal Story, and Lord Provost Chisholm took part in the interesting proceedings. The company thereafter, on the kind invitation of Professor and Mrs. Cleland, partook of afternoon tea.

GARTNAVEL ASYLUM, GLASGOW—THE MEDICAL SUPERINTENDENT.—We have just been informed that Dr. Yellowlees, lecturer on insanity in Glasgow University, and physician superintendent of the above asylum, has resigned, or is on the eve of resigning, the important office which he has held for a long period of years in connection with Gartnavel Asylum. The office is a responsible one, but at the same time it is, from a pecuniary standpoint, a very lucrative one, as it carries with it a handsome salary, free house, with concomitants, a carriage and pair of horses, and last, but not least, the liberty of private practice or consultation work in mental diseases. Already the names of one or two who are likely to be applicants for the vacancy have been mentioned. There is a gentleman of outstanding ability at present occupying a similar position, although it is not such a valuable one, who it is generally thought will succeed Dr. Yellowlees, who has discharged the duties of the office so creditably. The gentleman we refer to was a very distinguished student of Glasgow University. That said, however, the vacancy is such an important one that it will probably call forth applications from various quarters. The gentleman appointed will succeed to a remarkably snug position.

### Correspondence.

[We do not hold ourselves responsible for the opinions of our correspondents.]

#### THE PASTEUR TREATMENT OF HYDROPHOBIA.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—For the information of your correspondent "Scrutator," I quote the following paragraph which appeared in the *Globe*, the *Westminster Gazette*, and the *Evening News* of August 15th:—"The figures published by the sanitary authorities especially demonstrate the increase in hydrophobia in the French capital, and show the alarming proportions to which the malady is rapidly

growing. The deaths are said to have reached the enormous total of 8,079!"

Surely no further evidence is required to prove my assertion that these reports of the increase of hydrophobia in Paris are absurd and untrustworthy.

The following paragraph from *The British Medical Journal* of September 7th shows that the manufacture of "serum" is a very profitable business:—"In 1895 the Pasteur Institute, Charkoff, sold 59,267 doses of anti-diphtheria serum at a profit of nearly £2,500. The expenses of the Institute amounted to about £4,200, while the income was about £6,680."

For evidence of the truth of my statement that the Pasteurian anti-rabic treatment is useless and dangerous, I refer "Scrutator" to Dr. Dolan's work entitled "Pasteur and Rabies," to Dr. Charles Bell Taylor's article, "Pasteur's Prophylactic," in the *National Review* for July, 1890; to the writings of Dr. Lutaud of Paris (translated and published by the London Antivivisection Society), to my paper "On Rabies and Hydrophobia" in *The Medical Brief* for June, 1901, and to the published opinions of Dr. Spitzka, of New York, Dr. Charles Dulles, of Philadelphia, the late Professor Peter, of Paris, Professor Colin, of Alfort, Professor von Frisch, of Vienna, Professor Zienitz, of Warsaw, Dr. Abate, of Naples, the late Sir B. W. Richardson, and many others. This evidence, though too often ignored, has never been controverted, and I challenge "Scrutator" to refute it if he can.

I am, Sir, yours truly,

J. H. THORNTON, M.B., B.A.

Dy. Surgeon-General, I.M.S. (retired).

Hove, Sussex, September 17th, 1901.

#### THE BIOLOGICAL TEST.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The biological test in my relative's case had a positive and not a negative result. The animals inoculated died of tuberculosis. But as you, Sir, said in your note to my letter, the case was evidently one of chronic pneumonia, and if the biological test had any value at all the animals should have died of that disease. We have recently read of two deaths at Guy's Hospital from "tetanus," following subcutaneous injections of gelatine. But was tetanus the cause of death? Was the suspected gelatine tried on animals and did they suffer from tetanus? If it was so tested and the animals escaped are we at liberty to say that the patients in the hospital did not die of tetanus as the medical evidence seemed to prove? If they did so die it proves that the most elaborate precautions taken to sterilise the apparatus and material for inoculation are futile. Quite apart from the question of vivisection I am opposed to the biological test because I consider it extremely liable to mislead the practitioner who puts faith in it. As a matter of fact, and altogether apart from laboratory theories I do not believe that many practising physicians value it more than I do. Your correspondent—Mr. Sers—need hardly tell us that he knows very little of the anti-vivisection question. It is not the lives of the animals that most of us are concerned for, it is the torture, the infliction of severe and continued pain upon them, against which we protest. The majority of anti-vivisectionists are not vegetarians; they believe they have the right to kill animals for food if it be done mercifully. As to the question of the utility of vivisection, I believe that, compared with the suffering it entails, its value to practical medicine is infinitesimal; but were it ever so valuable we should condemn it on the principle that we must not do evil that good may come. The world had better be sick than pitiless. Mr. Sers' illustration about beef tea is an example of very poor reasoning. In the first place I deny that properly-made beef tea is valueless as food for invalids. The practice of the medical profession is against him, and I need not waste your space in refuting his proposition. The experiment on the dog is beside the question. Our patients are not dogs, but human beings. Kemmerich (I have read somewhere) discovered that he could kill dogs by injecting into their stomachs extract of horse-

flesh; they died with all the appearances of cardiac paralysis. I have not read of any human beings who have suffered the like from the ingestion of meat extract.

I am, Sir, yours truly,

EDWARD BERDOE, M.R.C.S., &c.

September 19th, 1901.

#### TOTAL GASTRECTOMY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In your issue of September 18th there appears an article by Mr. O'Hara, of Melbourne, on "Total Gastrectomy for Carcinoma of the Stomach."

I think a protest should be made against the misuse of the term "total gastrectomy." It is quite clear from Mr. O'Hara's description that only a portion of the stomach was removed. He writes: "The large opening in the cardiac end of the stomach was partially closed," &c., and again "There must be a sufficient amount of cardiac end free from disease to complete the anastomosis with the duodenum." In complete gastrectomy the specimen removed should show œsophagus at the one end and duodenum at the other, as in Schlatter's case.

Mr. O'Hara is not alone in his unfounded claim to have performed "total gastrectomy." I have carefully read all the records of cases so reported, and it is quite clear that in some of them a portion of the cardiac end of the stomach was left.

If Mr. O'Hara's description of the growth be accepted, of its extent along "about two-thirds of the distance between the pyloric and cardiac ends of the stomach," and if the stomach was "greatly dilated," it is impossible to see any adequate reason for a "total gastrectomy." Mr. O'Hara was therefore quite right in not performing one.

I am, Sir, yours truly,

Leeds.

B. G. A. MOYNIHAN.

#### LACHNANTHES TINCTORIA.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—If among the readers of the MEDICAL PRESS AND CIRCULAR there have been included any sufficiently ingenuous to have cherished the faintest hope that after all there might be "something" in the above-named "remedy" for consumption, the hope must have been shattered by the able letter of Dr. Murrell which appears in the MEDICAL PRESS AND CIRCULAR of to-day, August 18th. To the man of the world, being also a medical man, Dr. Murrell's evidence was not necessary to prove the character of the "cure" in question. Every medical man of the world would have previously been willing to pledge himself that no solid scientific data would be forthcoming to establish the claims put forth for the "Lachnanthes treatment," and that the only evidence adducible would consist in "testimonials from grateful patients" of exactly the same value as those which bear witness to the power of Holloway's pills and ointment to root out the totally distinct causes of several score of totally diverse diseases. Our knowledge of the physiology of the lungs is no doubt not absolutely perfect, and our acquaintance with the progressive morbid phenomena following tuberculous infection is no doubt not complete, but surely we have enough solid scientific fact to enable us to distinguish between rational therapeutical measures and procedures the success of which could only be accounted for as a miracle. It would certainly be something like a miracle if advanced tuberculosis of the lungs were curable by internal administration of Lachnanthes combined with inhalation of any form of vapour derived from that herb. The whole correspondence on the subject has no doubt been calculated to make the cynics sneer, especially those who detest the medical profession and the scientific methods by which medical progress slowly fights its way. In those who have sympathy with human misery the injury to which the correspondence has given rise will excite the reverse of a smile. The effect of the world-wide advertisement afforded by *The Times* has been to raise false hopes in

the hearts of a vast number of wretched patients to their ultimate injury or destruction. For this result Colonel Le Poer Trench is primarily responsible, although perfectly innocent of any but the purest philanthropic purpose. Perhaps by this time he perceives how much wiser it would have been if he had placed himself in the hands of advisers having a knowledge of science. No one would wish him the punishment which realisation of the harm he has done would surely inflict upon him.

I am, Sir, yours truly,

September 18th, 1901.

UBIQUE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I see you have fallen into the same mistake so many lay people have - that Mr. Alabone's treatment of tuberculosis consists of the administration of "lachnanthes" alone. Lachnanthes is only one of the drugs he recommends in his treatment, which is carried out chiefly by daily inhalations. He has perfected a comminutor for inhaling, by which 20 to 30 per cent. of formalin with other inhalants can be used. I can only say that for the last ten years I have recommended no other treatment for phthisis, when combined (as far as is practicable in our climate) with the open-air treatment, and I have had the good-fortune of seeing patients who have been given up as absolutely hopeless cases recover, and remain in good health.

Mr. Alabone has to my knowledge explained to many medical men every particular of his treatment, and more than one medical man has placed his sons and daughters under his care with the happiest results.

I think, too, it ought to be mentioned that Mr. Alabone's name was taken off the *Registrar* solely for a laudatory article and sketch which appeared in *Moonshine* in 1886, similar cartoons having appeared week by week of the late Sir Andrew Clark, Sir R. Quain, and other eminent medical men.

I trust that Colonel Trench's generous offer of £1,000 towards the expenses of having the above treatment "officially tested" may be carried out, and that I may live to see the day.

I am, Sir, yours truly,

HENRY J. BUCK, L.R.C.P.E., &c.

Clapton Common, N.E.,

September 23rd, 1901.

#### MEDICAL REFORM.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Under this heading in your editorial of last week you referred in favourable terms to a communication on the subject sent by me for publication. I regret that owing to its length you were unable to find space for it, for a perusal of the letter would have made several of your references to it more easily understood. The main object of my letter was to point out the great disproportion in numbers between the representatives in the General Medical Council of the qualifying bodies on the one hand and the medical practitioners on the other, and to emphasise the fact that this unfair distribution of representation is largely to blame for the unsatisfactory position in which medical affairs stand at the present day. I stated that while twenty members of Council are elected by the seventeen qualifying bodies, the 30,000 medical practitioners in the kingdom can elect five members only. In Scotland five qualifying bodies return seven members, while the 6,000 practitioners there return one member. My letter also showed that under the existing system certain evil results were to be feared from the quantity of qualifications by seventeen independent bodies pecuniarily interested in such granting and having different and in some cases inefficient standards of examination, and it was in dealing with this point that I referred to the one-portal system, indicating that a uniform State examination would be a good substitute for the seventeen varied examinations above described. My references to the one-portal system and to a Bill for putting down quackery were mere asides, but you seem to have misunderstood this. Though I referred

to it as the Medical Parliament, my remarks were not in any way intended to imply that the General Medical Council was actually a legislative body. But while of itself unable to legislate, there is no doubt that a strong representation on any medical subject from the Medical to the Privy Council would have a very good chance of becoming law. It is certain that the General Medical Council has power, by such representation, to increase the number of direct representatives, and this is the main point for reform in the meantime. If the medical societies throughout the kingdom will petition the Medical Council to request from the Privy Council an increase in the number of direct representatives the increase will be given.

Your suggestion that the electorate of the licensing bodies be enlarged is good and reasonable, and if the constituent members took up the question vigorously they could make out a very good case for admission to the electors' roll. Would it not, however, be a better plan to reduce the number of representatives for these licensing bodies by giving one representative to the several groups of colleges, universities, or other bodies which have much alike in their constitutions, their aims, and their general modes of procedure. Such an arrangement would benefit the financial department of the General Medical Council.

I am, Sir, yours truly,

ANGUS MACPHEE, M.D.

Glasgow, September 22nd, 1901.

## Acto Inbentions.

### A PERFECTED GAS FIRE.

IN discussing the advantages and drawback of gas fires some time since, we insisted rather emphatically on the noise which characterises most of the stoves in the market, and upon their almost universal tendency to "light back." Since then Messrs. Fletcher, Russell and Co., Limited, of Warrington and London, have invited our inspection of their various gas fires, and we have availed ourselves of the opportunity to go thoroughly into the matter.

We were struck by the fact that none of the stoves inspected could be accused of "roaring;" in fact, if the gas supply be properly regulated, they burn in absolute silence. More than this, thanks to an ingenious device, lighting back is an impossibility, as we have ascertained for ourselves. In view of the perfection to which these gas fires have been brought, one can only wonder that there is any sale for the ordinary gas stove, with its manifold inconveniences. Those manufactured by Messrs. Fletcher, Russell, and Co. throw out an unusually large proportion of the heat generated, and this without any disagreeable or other odour due to charring of the organic dust of the air.

We are fain to admit, therefore, that the objections which we raised on a previous occasion to gas fires in general do not apply to these, and we can conscientiously recommend them as highly ornamental and thoroughly efficient.

## Literature.

### MUNSON'S MILITARY HYGIENE. (a)

THE difficulty the reviewer finds in dealing with this great work is to convey some idea of its value in the space at his disposal. As a text-book of military hygiene it is far and away the best we have ever seen. We know no book to compare with it in fulness of information, excellence of arrangement, or clearness in writing. Of its one thousand octavo pages there is not one leaf of padding, and every line tells how deeply the author has studied his subject out of his practical experience. For the reader he brings things new and old from the treasury of his knowledge.

His systematic arrangement is admirable. He com-

mences with a chapter on the selection of the recruit, and shows that "The ineffective man weakens the ranks he was intended to strengthen. He serves but to fill the hospitals, load the trains on the march, consume supplies, and require the care of the effective and able-bodied to minister to his infirmities." He reminds Army surgeons that the strength of the Army is determined by the number of rifles in the field rather than the number of names upon the rolls. Lord Kitchener has recently been re-echoing these opinions. Napoleon in 1813 felt this, and in calling for recruits after the retreat from Moscow desired "men, not boys, who served only to encumber the hospitals."

Passing from the selection of the recruit he considers the development of the recruit, and remarks: "It is false economy on the part of the nation, and cruelty to the men to expose them to the privations of war, and the fatigue incident to campaign, without fortifying their constitutions and providing that reserve of strength, vitality, and endurance upon which they must draw, and without which they will break down." He considers the influence of exercise on the muscular system, the nervous system, upon the heart, and in relation to the chest and lungs, and fully discusses the subjects of exhaustion, overtraining, and proper physical proportions from a fulness of knowledge acquired by practical experience.

The march in campaign is next dealt with under the headings Preparation, The Step, Work Done on the March, Position on the March, Length, Meteorological Conditions, Terrain, Equipment, Forced Marches, Night Marches, Delays, Rests, Use of Fluids, Straggling, Convalescents, Mouth Breathing, Mental Occupation, Accidents of the March, Blisters and Excoriations, *Pied Force*, Heart Strain, Health. We enumerate these headings to show the thoroughness with which the author does his work.

Chapter IV. is devoted to the important subject of "Water," its quantity, sources, storage, and supply. For hospitals he thinks the supply should be practically unlimited. For stationary camps the minimum amount of water for each soldier should be five gallons. Separating tanks and filters are illustrated and receive very full notice, and details of Norton's tube wells and their method of being sunk are given. These wells were first used in the American Civil War, and since then have been generally adopted in foreign military service. Drinking water in its relation to disease, and the methods employed for the determination of its quality, together with the article on the purification of drinking water, are of such great value that we would like to see them read by all students of medicine, military and civil. The author's description of how water may be contaminated and the evils that arise from the use of such water, and how the water may be purified is a masterful exposition of our knowledge of the whole subject.

The soldier's ration in relation to work, the determination of the real nutritive wants of the body, the selection of the food, the association of foods, the proper cooking of the food, and their just distribution are all considered. Much stress is laid on the quality of the ration, and in this connection he dwells on the storage of perishable articles and the examination of such before use. Wastage of rations, savings from, and additions to, have not escaped notice, and a number of illustrations show the many varieties of field stoves in use. Beef, cattle, their weight, age, condition, health; the inspection of dressed beef, its age, sex, quality; the transmissible diseases of cattle; cysticercus, tuberculosis, anthrax, actinomycosis, and other diseases are passed under review, and the reader wonders can anything more be said of beef, mutton, pork, or bacon, when the author commences on horseflesh, and passes on to the consideration of healthy slaughter-houses and the preservation of meat, refrigerated and frozen, desiccated, sun-dried, smoked, and canned—nothing escapes notice, and instructions on salting and chemical preservatives come in for their due measure of description.

The general principles involved in the cooking of food are considered, and boiling, stewing, roasting, broiling, baking, and frying are told in a series of articles that would form a good text-book for a cookery class. Fish,

(a) "The Theory and Practice of Military Hygiene." By Edward L. Munson, A.M., M.D., Captain, Medical Department, United States Army. Illustrated by Eight Plates and nearly 400 Engravings. London: Baillière, Tindall, and Cox. 1901. Price 32s.

fresh and dried, pickled and canned, next demands attention, and then bread and vegetables. Of bread we are told everything, from the examination of the flour to the finished loaf, not omitting the many bacilli which may be found both in the raw material and the cooked ration. The illustrations of the bacilli are alarming looking, but we suppose their hideousness is drawn from nature.

Tea, sugar, coffee, and condiments are then discussed, and of sugar he adopts Schumberg's conclusion that "sugar in small doses is well adapted to help men to perform extraordinary muscular labour," and he recommends chocolate as the best medium. He gives an excellent receipt for making coffee, which many housekeepers might read with advantage.

So far Dr. Munson has merely dealt with the ordinary rations, and he afterwards discusses emergency or reserve rations very fully.

Some fifty pages are devoted to military clothing and equipment. We are sorely tempted to quote his article on the head covering, and his account of the influence of colour in protecting the soldiers from sunstroke, but space will not allow of it.

This chapter practically ends the first part of the book, and chapter eight commences with the general principles that guide the military sanitarian. Commencing with camp sites and camps, he considers topography, soil, moisture, water, soil temperature, bacteriology, and vegetation. Those of our readers who have studied the sanitation of the recent American campaign in Cuba and the French invasion of Madagascar will recognise the importance of the subject, and those who have read Surgeon-General Laid's account of the Spanish Army in the Cuban War will recognise somewhat of the difficulties that beset the military surgeon in choosing his hospital sites. Numerous illustrations in the article "Camp" greatly aid the reader in following the descriptive letterpress of the plan of the camp, its area, bivouacs, cantonments, shelter-tents, hospital tents, and tents in general. The military authorities, as well as the general public, have come to recognise that disease kills more than either the rifle or the sword in modern wars.

He commences his chapter on posts, barracks, quarters, and hospitals by accepting Parkes's well-known requirements for a healthful habitation; and the article is profusely illustrated, to the great comfort of the reader, who has no difficulty in recognising the different plans that varying circumstances call for during war. Ventilation is next dealt with, its influence on health, drafts, intakes, and so forth, with descriptions and illustrations of its many methods, occupies some fifty pages.

Heating and lighting naturally follow, the relative value of the different fuels is considered, and the many methods of local and general heating described and illustrated.

Fifty pages follow on the disposal of excreta, sewage, and refuse. He deals with the advantages and disadvantages of the cesspool system, the pail system, the dry-earth system, and the Gorse system. Sewers, their sanitary value, their construction, their site, the velocity of their flow, their gradient, their discharge, and sewer-air all come in for treatment by the author. The technicalities of drainage and plumbing, sewer pipes, latrines, and the disposal of sewage secure due consideration. He next takes up the question of the personal cleanliness of the soldier, and opens chapter thirteen with the statement, which we heartily endorse, "The maintenance of personal cleanliness is even more essential in the military service than under the ordinary conditions of civil life."

Military mortality and morbidity and diseases of the soldier are discussed in 160 pages; of the military surgical records from the Memoirs of Baron Larrey to Senn's Report on the Spanish-American War, we know no book so full, so clear, so trustworthy a guide on these subjects as the work under notice. Disinfection is next considered, and we recommend this description of chemical and other disinfectants to all health officers, particularly to those having charge of infirmaries, hospitals, and such-like buildings.

The habits of the soldier, under the headings alcoholism, the canteen system, venereal disease, the use of tobacco, tattooing, his amusements, insanity, and suicide, the hygiene of hot and cold climates, of the troopship, sanitary inspection, and the disposal of the dead, conclude this great work.

Great in its fulness and accuracy, its clearness of information and excellence of arrangement, and great in the mastery of his subject that the author displays.

Written for military surgeons, the book is withal invaluable to public health officers, medical officers of infirmaries and workhouses, for surgeons in charge of segregated bodies of men, for headmasters of public schools, and for all who take an interest in preventive medicine and practical hygiene.

#### CLARKE'S NEW THERAPEUTICS. (a)

THIS work has reached a sixth edition, so that presumably there is some demand for it. It may be described as a catalogue of diseases, with indications for treatment. We will take an example. Under the heading of Enteric Fever we find: "At the very commencement when it is not absolutely certain whether it is true typhoid or low gastric fever, *Septicæmin*." We must admit that we have never met with such a case, and are not very clear what is meant by "low gastric fever." "Low Fever" and "Slow Fever" are somewhat antiquated synonyms for enteric fever, and the term "Gastric Fever" is sometimes met with in the works of the older writers, but we do not remember to have seen a case of "low gastric fever" in the wards of any hospital, and we were not aware that it was a complaint likely to be confounded with enteric fever. Possibly the author might find Widal's reaction an aid to diagnosis. At all events, should there be an epidemic of such cases, *septicæmin* is the appropriate remedy, and it should be given "30-200, 4h." Whether this would cure the patient or kill him outright we are not informed. There seems to be some mystery about *septicæmin*, but from another part of the work we gather that it is an abbreviation for *septicæminum*. What is its origin and how it is prepared we are not informed, but possibly that might be ascertained from a study of the author's "Practical Materia Medica." Other remedies suggested for enteric fever under various circumstances are "agar," "ecchin," and "pyrogen." "Agar" is probably *agaricus muscarius*, a drug with which we are familiar; "ecchin" we find is *ecchinacea angustifolia*; whilst "pyrogen" is another name for *sepsin*. This is all very well as far as it goes, but we should like to know how a medical man brought up on such pabulum would conduct an ordinary case of enteric fever. It seems to us that his knowledge of the etiology and pathology of the disease would be utterly thrown away, whilst the condition of the patient, if these drugs have any action at all, would be critical. Supposing as a complication the patient were to develop tympanites or peritonitis, or perforation or hyperpyrexia, is it at all likely that "agar," or "ecchin," even with the mystic symbols attached, would do any good? We may fairly ask that our author should be reasonable, or at all events that he should show some practical knowledge of the clinical aspects of the disease. We have no desire to characterise his recommendations as utter nonsense, but we might do so in all good faith. Would it not be better that he should describe one or two carefully observed cases of enteric fever treated on the principles that he has enunciated, and that he should give some account of the pharmacological actions of the numerous drugs of the "New Therapeutics" which he advocates? We have not the slightest doubt that he is sincere in his convictions and that he has spent much time in the compilation of the work, but we cannot refrain from asking the question:—"What good is it, and what does it all lead to?" It is not pathology, it is not therapeutics, and it is not the practice of medicine, at all events in the sense in which we understand these terms.

(a) "The Prescriber: A Dictionary of the New Therapeutics." By John Henry Clarke, M.D. Sixth Edition. London: 12, Warwick Lane, E.C. 1900.

## AN INDIAN TREATISE ON MATERIA MEDICA. (a)

THIS little work, which consists of 198 pages, and is presumably intended for the use of students in the author's class in the Calcutta Medical School, is a useful compilation. It makes no pretence to originality, and the facts and tables have been gleaned from well-known sources. The writer has made the most of his opportunities, and has arranged his material in a manner which cannot fail to be of service to men preparing for examination in this somewhat unpopular subject. There is but little to criticise, and the only errors we have detected are misprints, chiefly in the transcription of authors' names. Even in the preface there are signs of imperfect proof-reading, but these will probably be corrected in future editions. Apart from this the work is well done and reflects credit on the author.

## Medical News.

### Dublin Death-rate.

IN the Dublin registration area the deaths registered for the week ending Saturday, September 14th, 1901, were 164. They represent an annual death-rate of 22.8 in every 1,000. During the thirty-seven weeks ending Saturday, the 7th inst., the death-rate averaged 26.8, a slight increase on the corresponding period of the past ten years. Sixty-four of the persons whose deaths were registered during the week were infants; of whom thirteen were under one month old, and forty-three under one year old, an infant mortality probably unequalled in any other city. A disgrace to our civilisation.

### Death Under Chloroform.

A DEATH under chloroform at University College Hospital was the subject of an inquest last week. The victim was a man, age 47, who was undergoing an operation on the mouth. The usual verdict was returned.

### Death from an Overdose of Morphine.

AN inquest was held on the 18th inst. on the body of Dr. Carmichael, of Southport, who had succumbed to the effects of an overdose of morphine taken to induce sleep. The deceased was seventy-eight years of age. A verdict of death from misadventure was returned.

### The Road to Ruin.

FRANCIS SCOTT SANDERS, formerly a medical man, whose name was removed from the *Medical Register* some years ago, consequent upon his conviction for forgery, was last week sentenced to a term of imprisonment for several more cheque frauds perpetrated at the expense of Dr. Evans, of Pimlico, and others.

### Another Midwife Scandal.

AN inquest was held a few days since by the Coroner for Westminster on the body of an infant male child, who was stated to have died of convulsions two hours after birth. The midwife nevertheless took the body to the undertaker in a shawl and certified it as still-born. The inquiry was adjourned, and it is to be hoped steps will be taken to impress upon the midwife the extremely serious nature of the offence.

### Koch's Theory in Court.

A BEGGAR in Hamburg was recently in court on a charge of vagabondage, and his defence was that six months previously he had contracted tuberculosis in slaughtering a cow, which had rendered his right arm useless, and this statement was borne out by the hospital doctor. He was accordingly discharged.

### The Sanitary Institute.

A DONATION of £100 has been promised by the Leeds Fireclay Company to the fund for the new building and endowment fund of the Parkes Museum.

### Mosquito Models.

A CASE of model mosquitoes has just been placed in the great hall of the Natural History Museum, South Kensington. The models, which have been beautifully made by Miss E. D. Emmett, are twenty-eight times natural size. Of the two models, one, the *Anopheles*

*Maculipennis*, is the malarial parent, the other is the common grey gnat, *Culex Pipiens*. The latter insect has light bands round his body, and one proboscis, while the former has no bands, but three proboscoides.

### A Municipal Convalescent Home.

AN interesting experiment is being carried out by the Health Department of Halifax Corporation. This is the opening, at Birks Hall, Pellon, of a convalescent home for scarlet fever patients. Experience has shown that, when patients have been discharged direct from the Stoney Royd Fever Hospital, there have been a number of what are known as "return cases," through some other member of the family developing the disease. The patients are now to be isolated at Birks Hall entirely from acute infection for a fortnight before being finally discharged. It is intended, if the experiment answers anticipations, to provide and maintain a permanent convalescent home in the town.

### Vital Statistics.

THE deaths registered in the week ending September 14th in 36 large towns of Great Britain and Ireland corresponded to an annual rate of 21.8 per 1,000 of their aggregate population, which is estimated at 11,463,026 persons in the middle of this year:—

Birkenhead 20, Birmingham 22, Blackburn 17, Bolton 19, Bradford 15, Brighton 16, Bristol 16, Burnley 24, Cardiff 14, Croydon 16, Derby 13, Dublin 22, Edinburgh 16, Glasgow 17, Gateshead 28, Halifax 17, Huddersfield 14, Hull 20, Leeds 18, Leicester 17, Liverpool 19, London 16, Manchester 23, Newcastle-on-Tyne 27, Norwich 17, Nottingham 16, Oldham 22, Plymouth 11, Portsmouth 16, Preston 24, Salford 26, Sheffield 20, Sunderland 24, Swansea 15, West Ham 17, Wolverhampton 21. The highest annual death-rates per 1,000 living, as measured by last week's mortality, were:—From scarlet fever, 1.2 in Bolton; from whooping-cough, 1.4 in Gateshead and 1.7 in Leicester; from "fever," 1.1 in Swansea, in Nottingham, in Huddersfield, and in Sheffield, and 1.9 in Birkenhead; and from diarrhoeal diseases, 5.0 in Birmingham, 5.6 in Hull, 5.7 in Sunderland, 5.9 in Manchester and in Sheffield, 6.0 in Preston, 6.4 in Salford, 7.7 in Wolverhampton, and 8.0 in Gateshead. In none of the large towns did the death-rate from measles reach 1.0 per 1,000. The 80 deaths from diphtheria included 28 in London, 9 in Sheffield, 6 in West Ham, 4 in Bristol, 4 in Manchester, 3 in Glasgow, 3 in Leicester, and 3 in Gateshead. Nine deaths from small-pox were registered in London, but not one in any other of the large towns.

### The Mortality in Foreign Cities.

THE following are the latest official returns, and represent the last weekly death-rate per 1,000 of several of the populations:—Calcutta 28, Bombay 56, Madras 76, Paris 17, Brussels 13, Amsterdam 14, Copenhagen 21, Stockholm 13, Christiania 18, St. Petersburg 21, Moscow 29, Berlin 24, Hamburg 18, Breslau 28, Munich 32, Vienna 15, Buda-Pesth 14, Trieste 21, Rome 18, Venice 23, Cairo 47, Alexandria 42, New York (including Brooklyn) 22, Philadelphia 19.

## Pass Lists.

### Society of Apothecaries of London.

THE following candidates have passed in their respective subjects during the September examinations:—Surgery: H. Richardson (Sections I. and II.), C. W. Rowntree (Sections I. and II.)

Medicine: C. J. E. Edmonds (Sections I. and II.), E. L. Jones (Sections I. and II.), G. J. W. Keigwin (Section II.), C. A. Lower (Section I.), C. W. Rowntree (Sections I. and II.)

Forensic Medicine: C. J. E. Edmonds, E. L. Jones, O. Millauro, C. W. Rowntree, H. Smith.

Midwifery: C. H. Allan, E. O. Libbey, C. W. Rowntree, W. P. Taylor, J. H. Williams.

The L.S.A. diploma was granted to the following candidates, entitling them to practise medicine, surgery, and midwifery: C. J. E. Edmonds, E. L. Jones, G. J. W. Keigwin, C. W. Rowntree, and H. Smith.

(a) "A Treatise on Materia Medica and Therapeutics, including Pharmacy, Dispensing, Pharmacology, and Administration of Drugs." Vol. I. By Bakhaldas Ghosh, L.M.S., Lecturer on Materia Medica, Calcutta Medical School. Calcutta: Hilton and Co. 1901.

## Notices to Correspondents, Short Letters, &c.

REPRINTS requiring a reply in this column are particularly requested to make use of a *distinctive signature* or *initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the publisher or printer before the type has been distributed. This should be done when returning corrected proofs.

ORIGINAL ARTICLES or LETTERS intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication, but as evidence of identity.

### NEWSPAPER PHYSIC.

It is to be hoped that with the advent of real education there will be some decrease of the vast amount of quackery that is foisted upon the public. In the pages of a well-known journal written for the domestic circle appeared a short while since what purported to be a reply to a fair correspondent who had asked how she could cure an uncomfortable habit of flushing. The answer began with the remark that the symptom evidently arose from nervousness, and that must be cured in the first place. Then followed about twenty or thirty lines of directions. The blushing correspondent was directed to buy some preparation with a quaint name, for use in the morning bath. The stuff cost half a crown, but on the other hand it was "invigorating and beautifying." She was then to have her spine rubbed up and down until the skin was in a glow with another half-crown preparation. She was directed to bathe her face frequently through the day with a tannin preparation sold at the ridiculously low price of one shilling and sixpence. After the lotion she was advised to use camphor water, or "better still," a lotion of half a crown. The latter is cheap at the money, for it is not only cooling and refreshing, but it imparts a velvety softness to the skin. The paragraph concludes with the advice "Not to think what other people think," but follow the foregoing directions and "you will soon lose that tendency to flushing." A course of this kind would infallibly ruin the strongest skin on earth. How women can allow their money to be wheeled out of them by such nonsense is a thing "no fellow can understand." If he wanted to be beautiful for ever he would resort to yellow soap and a jack-towel.

DR. MURRELL'S paper on "The Value of Age and Sex as Etiological Factors in the Differential Diagnosis of Gastric Ulcer and Carcinoma" is marked for early insertion.

### THE STATISTICS OF THE IRISH HOSPITAL IN SOUTH AFRICA.

WE hasten to correct an error which in some curious manner seems to have crept into Dr. Coleman's article on "Medical Experiences in South Africa," which appeared in our last issue. The total mortality among the cases treated in the Irish hospital was wrongly given as 18·7 per cent. It should have been 11·7 per cent., a very material difference.

PHYSICIAN.—"Cardioptosis," otherwise called Bummo's Disease, is ascribed to a weakness of the suspensory structures of the heart in neurasthenics, particularly of the bundle of blood vessels in which the elastic elements are not sufficiently developed to sustain the heart in its normal position. A translation of a paper on the subject appears in the issue of the *New York Medical Journal* for August 24th, 1901.

### THE MEDICINAL QUALITIES OF PURE BRANDY.

A CORRESPONDENT writes us that he has recently read in one of the newspapers that very little pure brandy now exists containing those natural medicinal qualities which won for it the favour of former years as the most valuable of all stimulants. He asks whether this wholesale thrust at one of the medical sheet anchors is true, or only the outcome of interested parties in the whisky trade. As to the latter we cannot inform him, although his surmise may have some indirect bearing; but with the former question we are in the position to assure him, as the result of careful analyses of several samples of Cognac brandy, that it is as pure as it ever was, and that he may continue to prescribe it wherever indicated with the same confidence as formerly, provided he specifies the best known brands. The recent case in the law courts in which it was found that a cheap composition was sold under the name of brandy which had not been produced in the brandy district of Cognac has undoubtedly had much to do with the report referred to. Pure Cognac cannot be purchased at the price of whisky, but the genuine article can be had at its market value.

OUR FRENCH CORRESPONDENT.—The Clinical Lecture by Professor Robin on "The Treatment of Gastric Ulcer" has been received.

## Appointments.

GILMER, H. A. H., M.B., Ch.B.Edin., House Surgeon to the David Lewis Northern Hospital, Liverpool.  
LIVINGSTONE, THOMAS H., M.B., Ch.B.Edin., District and Work-house Medical Officer of the Weardale Union.  
MACKENZIE, F. D. S., M.B., Ch.B.Edin., Assistant House Surgeon to the David Lewis Northern Hospital, Liverpool.

BABY LEONARD, M.D.Durh., M.B.C.S.Eng., Medical Officer of the Second District of the Devises Union.  
SNOW, C. B., M.B., Ch.B.Edin., House Physician to the David Lewis Northern Hospital, Liverpool.  
STROVER, WALTER, M.B.C.S.Eng., L.S.A., Medical Officer of Health of Chingford.  
WATTS, ALEXANDER, M.B.C.S.Eng., L.B.C.P., Medic 1 Officer of Health of the Holbeck Urban District.

## Vacancies.

Cork Street Hospital and House of Recovery.—Assistant Lady Superintendent and Matron. Salary £40 per annum, with board and uniform. Applications to be sent to J. Marshall Day, Registrar and R.M.O. (See advt.)  
County Asylum, Burntwood, near Lichfield.—Junior Assistant Medical Officer. Salary £150 per annum, increasing to £200, with board, lodging, attendance, and washing. Applications to the Medical Superintendent.  
East Riding of Yorkshire.—County Medical Officer of Health. Salary £400 per annum, rising to £500 per annum, with certain allowances. Applications, on forms to be obtained from the Clerk, to be sent to the Clerk of the County Council, County Hall, Beverley. (See advt.)  
Essex County Asylum, Brentwood.—Junior Assistant Medical Officer, under 26 years of age. Salary £140. Applications to the Medical Superintendent.  
Hertfordshire County Asylum, Hill End, St. Albans.—Junior Assistant Medical Officer, unmarried. Salary £160 a year, with board, furnished apartments, and washing. Applications to the Medical Superintendent.  
Lancashire County Asylum, Winwick, Newton-le-Willows.—Senior Assistant Medical Officer. Salary £225 per annum. Also Second Assistant Medical Officer. Salary £175 per annum. Also Assistant Medical Officer. Salary £150 per annum. All with board, lodging, and washing.  
Monsal Fever Hospital, Manchester.—Medical Superintendent, unmarried. Salary £350 per annum, with residence, maintenance and attendance.  
North Wales Counties Lunatic Asylum, Denbigh.—Second Assistant Medical Officer. Salary £120 per annum, rising to £160, with board, residence, and washing. Applications to the Clerk of the Visiting Committee.  
Owens College, Manchester.—Junior Demonstrator in Physiology. Salary £100 per annum, rising to £150 per annum. Applications to the Registrar, from whom further particulars may be obtained.  
Royal London Ophthalmic Hospital, City Road.—Curator and Librarian. Salary £120. Applications to the Secretary.  
Somerset and Bath Lunatic Asylum, Cotford, Taunton.—Assistant Medical Officer. Salary £120 per annum, rising to £150, with furnished apartments, board, and washing. Applications to the Medical Superintendent.  
Worcester County Asylum, Powick.—Third Assistant Medical Officer. Salary commencing at £120 per annum, increasing to £140, with board, residence, &c. Applications to the Medical Superintendent.

## Births.

DUNN.—On September 19th, at Mildehall, Suffolk, the wife of William Dunn, M.B., of a daughter.  
HICKSON.—On September 22nd at 64, Gloucester Place, London, W., the wife of Major G. B. Hickson (late R.A. Medical Service), of a daughter.

## Marriages.

AVENT—NOCK.—On September 17th, at the parish church, Alvechurch, by the Rev. John Avent, M.A. (father of the bridegroom), Arthur Avent, L.B.C.P., to Kate Hurd, daughter of the late J. B. Nock.  
CORBEN—OCKENDEN.—On September 17th, at St. George's, Hanover Square, London, Charles Corben, M.B.C.S., to Annie Bulmer, widow of the late E. J. Ockenden, and daughter of the late Major John Godson, Madras Staff Corps.  
REID—MITCHELL.—On September 20th, at Christ Church, Hampstead, James William, second son of James Reid, F.R.C.S., of Canterbury, to Edith Harriett, younger daughter of the late Francis Henry Mitchell, of Hampstead.  
STEVENSON—LAMB.—On September 17th, at St. Mary's Church, Ealing, Walter Brodie Stevenson, M.B.C.S.Eng., L.B.C.P. Lond., to Annie, daughter of William Douglas Lamb.  
WORTH—SHEPARD.—On September 17th, at St. John's Church, Eton, Francis James Worth, M.D., B.S., L.R.C.P., M.B.C.S., to Margaret Louisa, daughter of the Rev. J. Shephard, vicar of Eton.

## Deaths.

ANDERSON.—On September 19th, at Hallyards, Peebleshire, William Anderson, M.D., of Hallyards, and of Richmond, Surrey, aged 63 years.  
BALFOUR.—On September 11th, at 15, Marmaduke Street, Liverpool, Alice, wife of David Balfour, M.B. and C.M., aged 90 years.  
DOUGLAS.—On September 18th, at Bellingdon Road, Chesham, James Richard Alexander Douglas, M.B.C.S., L.S.A., of Hounslow, in his 83rd year.  
MORAN.—On September 20th, in London, Lieut.-Colonel James Moran, M.D., of the Indian Medical Service.



# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXIII.

WEDNESDAY, OCTOBER 2, 1901.

No 14.

## Paris Clinical Lectures.

### THE TREATMENT OF BRONCHITIS AND BRONCHO- PNEUMONIA IN CHILDREN.

By Prof. MARFAN, M.D.,

Hopital d'Enfants, Professor of Clinical Medicine in the  
University of Paris.

[REPORTED BY OUR FRENCH CORRESPONDENT.]

I TAKE for the subject of this lecture the treatment of bronchitis and of broncho-pneumonia in young children. Some years ago the therapeutics of these affections were much encumbered; the remedies employed were very numerous, and you know that the proverb "Apparent riches mask real poverty" holds good here, a multiplicity of remedies recommended for a malady being a proof of their slight efficacy. I have no desire to recapitulate all the remedies tried for the last ten years. I will limit myself to indicating those which I have found the most useful.

No matter what form of infection of the lungs we have to deal with, whether simple bronchitis, capillary bronchitis, or broncho-pneumonia, there are *certain measures which must be taken in every case*, even the most simple.

Infants suffering even only from tracheo-bronchitis must be kept indoors at least ten days, in a room well-aired and lighted, and at a temperature of 63° F. It is well, also, that the atmosphere of the room should be saturated with water vapour; humidity, in fact, acts favourably in facilitating the expulsion of the bronchial secretion. The object can be easily obtained by placing a kettle of water over a spirit lamp. At the period of decline of the affection, a few leaves of eucalyptus can be thrown into the water, and thus the air which the child breathes will be loaded with balsamic vapour.

It is common to meet with symptoms of infection of the mouth and throat in children suffering from bronchitis or broncho-pneumonia, and often it is by *descending* infection that affections of the broncho-pulmonary apparatus are provoked; their habitual point of origin is the region where the third tonsil, the tonsil of Luschka, is situated. In case of bronchial infection it is rare that there does not exist supuration of this region, even in the absence of any adenoid vegetation.

It is consequently necessary to effect the antiseptics of this cavity by the aid of an ointment. The one we use in this hospital is composed as follows:—

Boric acid, ʒj;  
Menthol, grs iii;  
Vaseline, ʒj.

In order to make this ointment penetrate, the child is placed horizontally, the head hanging down backwards; then with the point of a probe with

cotton wool, or even the finger, a little of the ointment is placed in the vestibule of the nose, the child being kept in position for a minute or two, until the ointment melts and runs down the nostril. In a child of five or six the operation is even simpler; with the head as in the first case a few drops of a solution of menthol in oil (1—50) is poured into the nares twice a day. No attempt at washing through the nose should be made.

Where infection exists in the mouth, stomatitis with or without ulceration, touch the gums, lips, or fauces with a solution of carbolic acid (1—200) if ulceration be absent, otherwise employ oxygenated water.

Thus, in every form of bronchitis ensure asepsis of the mouth, nose, and pharynx; you will thereby prevent relapses.

There is another precaution which you should never neglect; it is to recommend change of posture. In young children, as in old persons, the dorsal decubitus favours the accumulation of the secretions in the bronchi. You must consequently insist that care be taken not to leave the child always on its back, but to place it now and again on either side, and to take it frequently in the arms.

I come now to the treatment of the different forms of bronchitis.

*Tracheo-bronchitis* (inflammation of the trachea and the large bronchi).

In this case counter-irritation must be employed at the outset. Mustard poultices twice a day, in the morning on the back, in the evening on the chest. The skin of young children is very delicate, consequently the poultices should be left on only as long as is required to redden the skin. Ought this to comprise the whole of your treatment, or should you employ internal remedies? In my opinion you should take care not to interfere with the phenomena of natural defence, particularly the cough, more useful to children than to any other patient, hindering, as it does, the propagation of the malady to the smaller bronchi. For that reason I advise you to order no internal treatment, unless the cough be out of proportion to the degree of inflammation, and if it prevents sleep. In such a case you can prescribe the following mixture:—

Syrup of orange flowers } a a ʒiv;  
Syrup of codeine  
Tincture of aconite, ℥v;  
Water, ʒj.

A teaspoonful a day for every three months of the child's age. In this dose codeine is without danger even in the youngest children, and gives good results.

Throughout the duration of the affection, as in every form of bronchitis, you should follow closely the evolution of the malady, thermometer in hand, and the ear on the chest; twice a day the temperature must be taken and the patient examined to see if the collateral bronchi are not affected in their turn,

which would constitute a prelude of capillary bronchitis, always to be feared in children.

If the collateral bronchi are invaded, instead of large bullæ you will hear sharp sibilant râles and mucous râles. If no fever be present it will not be necessary to employ more active treatment than that already mentioned, counter-irritation and cough mixture. If slight fever be indicated by the thermometer (100° F.) you will apply mustard, but you will take care not to give any sedative mixture. The secretion of the bronchi must be got rid of by the cough, consequently you must aid the cough by expectorants. If the child is over a year old and otherwise strong you will give an emetic, such as ipecacuanha, and renew it every three or four days, but when you have to do with a child under one year you had better abstain from it, as it only contributes to lower the strength and provokes diarrhœa. You might, however, administer the following mixture, which, although it will not provoke either nausea or vomiting, exercises a tonic action on Reissessen's muscles, and on the vessels:—

Hippo powder, ii grs ;  
Boiling water (filter, add), ʒij ;  
Syrup of tolu, ʒj ;  
Acetate of ammon. liq., ℥xv.

A teaspoonful in the day for each quarter of a year.

The third form, diffuse bronchitis, with fever, must be treated energetically; incessant cough, accelerated respiration, mucous râles distributed over the lungs; high fever 100°—103° F.; all signs indicating approaching capillary bronchitis. Here the hot bath is absolutely necessary. The temperature of the patient is taken every three hours, and when ever the fever reaches 103° F. a bath at 100° must be given. The effect is very remarkable. Improvement is almost immediate; respiration becomes more active and deeper; the pulmonary ventilation is better; the temperature drops a little; diuresis is abundant, and after the bath the child sleeps quietly. After four or five baths the temperature falls definitely below 103°, that is to say, in twenty-four or forty-eight hours. When the friends refuse the bath, or if no means for it are at your disposal, the treatment of Hensch, of Berlin, will form a good substitute. You take a towel folded in eight and dip it in ordinary cold water; you wring it out and apply it to the thorax of the patient, covering it with an oilskin; you leave it in place for two hours and renew it, and so on every two hours for twenty-four hours. The following day you perform the same operation four times in the twenty-four hours, leaving the towel *in situ* an hour and a half each time. The results are similar to those of the hot bath.

I now come to the treatment of capillary bronchitis. Here, again, warm bathing is *de rigueur*, and twice a day mustard should be put in the bath. When the person who holds the child in the mustard bath feels the skin of her arms commence to burn the child must be taken out. Warm and mustard baths consequently constitute the main treatment of capillary bronchitis and broncho-pneumonia. But it will often be well to combat the infection by injections of serum; the following is the formula I prefer:—

Chloride of sodium, gr. 4 ;  
Casein, 0·10 ;  
Water, 18 ounces.

For a child of six months, six drachms are injected in the morning and the same quantity in the evening, for a child a year old one ounce, and three years old an ounce and a-half. If the patient is threatened with collapse, or asphyxia, it would be well to inject camphorated oil (1-10), five drops for a child under

six months, ten drops under a year, and twenty drops for a patient in its second year.

Care must be taken to keep up the strength of the patients by food and stimulants. Under fifteen months milk alone should be given, over that age eggs may be beaten up with the milk. As stimulants, tea, coffee, and the following mixture:—

Tincture of cinnamon, xv drops ;  
Cognac } iv ;  
Syrup of ether }  
Acetate of ammonia liq., gtt. xv ;  
Syrup of acacia, ʒij.

To be given by teaspoonfuls.

Such is the treatment of capillary bronchitis and acute broncho-pneumonia. In the period of decline of any of the above forms, you should order the chest and back to be rubbed night and morning with equal parts of olive oil and essence of turpentine, and apply a layer of cotton wool; in children under six months balsams are not well borne, but in older children you can give the following mixture:—

Terpine, vi grs ;  
Benzoate of soda, xii grs ;  
Syrup of acacia, ʒij.

### DIET IN RELATION TO THE CAUSE AND CURE OF CONSTIPATION.

By JOSIAH OLDFIELD, D.C.L., M.A.Oxon,  
L.R.C.P.Lond.,

Senior Physician to the Hospital of St. Francis, and to the Oriole Hospital, Loughton.

WHEN I first began to undertake the difficult task of diagnosis, I used to ask patients "Are your bowels regular?" And I was satisfied with the answer "Yes," until I was one day startled by the discovery that a patient who had previously given me this answer had not had a motion for nearly week, and upon further inquiry I found that it was her usual experience to have a motion every Sunday morning after a late breakfast, and before going to church. This was the patient's idea of a regular motion, and further observations and inquiries had led me to find—what everyone who has much to do with diseases of digestion, finds—that to many women their bowels are as regular as their menses, namely, once a month, if they do not take pills.

The great prevalence of constipation in the human race is a matter of the gravest importance, and one which confronts every physician all through his practice. Perhaps more fortunes are made directly and more lives lost indirectly through this trouble than through any other single complaint. Patent medicines, prescriptions, and infallible remedies abound, but the evils still more abound, and with increasing civilisation it, too, increases. It is, therefore, worth while considering with care any new light that can be thrown upon its causation and cure. I remember one day having very great sympathy with a dog; it had been agonising for a long time over a particularly refractory stool, and while it was still struggling and I still sympathising, a herd of cattle passed by, and as they passed along one cow began to drop the usual fluid faecal matter. It suddenly struck me as a curious fact in nature that cats and dogs often had difficult motions, but that I had never known a cow to be thus troubled, and horses only sparingly so, and that when they had been kept for a long time from grass. I did not think more of the matter than merely to let my mind recall the popular craze of green laxative without trying to solve the reason of this effect. Years after I came across a wonderful life-history of the liver fluke, and learned what was

the ultimate end to which a correct constipation patiently persisted in would lead. The liver fluke, bathed in nutritious juices containing but a minimum of waste matter, finds that his lower bowels are useless, and when at length, by long disuse these have atrophied, he becomes the happy possessor of a stomach and diverticula without intestines or anus; the happy possessor of a digestive system without the need for an excretory one; the happy possessor of organs which need no purgatives. When the problems of constipation became pressing ones in practice I recalled some of my old observations and learned the following lessons:—

1. Concentrating nutriment leads to constipation.
2. A certain amount of bulk and waste matter is necessary to secure frequent defæcation.
3. A vegetable diet tends to a laxative state and a flesh diet to a constipated state.

At first I was inclined to include the third heading under the other two, and to assume that the vegetable diet was laxative because it was more bulky and contained more waste matter than a flesh diet. Later observations, however, led me to alter my views; I found, for example, that young summer spinach, which contains but a minimum of waste matter, was even more laxative than the toughest old cabbage with a maximum of indigestible cellulose matter. I found, too, that a great number of my patients who lived upon generous meat dietary had large abdomens, with their intestines full of fæcal matter, and that the presence, therefore, of much undigested matter in the intestines was not in itself enough to make the intestines empty themselves. To refer again to a test dietary, spinach and butter, which contain practically a minimum of bulk in its waste matter, was gently laxative, while beef-tea, which also contained little bulk in its waste, and also contained a large proportion of water, was constipating, and milk, though it contained a large proportion of fæcal waste, was also constipating. I was led by observations, extending over a large number of cases, to exclude from a large percentage the usually accepted theory that the ingestion of a considerable portion of waste matter was essential to, and was the chief cause of, a natural and regular motion of the bowels. Had this been true the cure of constipation would have been the simplest of simple things, instead of being, as it is, one of the most difficult of modern problems. While, therefore, I recognise that the ingestion of bulky foods containing a fair percentage of indigestible waste is one cause of defæcation, and while I recognise the important function of the irritating elements of food, *e.g.*, bones in the dietary of a dog, flints in the dietary of a fowl, bran spicules or fig seeds in the diet of a man; I do not consider that either or both of these solutions is sufficient to deal comprehensively with the great number of constipations in our midst. Still less do I look upon the ingestion of such irritants as magnesium sulphate, charcoal, or colocynth, or any of the great variety of purgatives as in any way to be considered the best method by which a regular action of the bowels can be secured.

For want of time, also, I omit all reference to the question of:—

1. Regularity of going to the closet, and thus setting up a nervous rythm.
2. Abdominal massage and intestinal kneading.
3. Enemata and intestinal flushings.
4. Mechanical injury to intestinal blood circulation by initial fæcal masses.

And I proceed at once to say that when the presence or absence in bulk or irritation does not solve the problem of constipation it can generally be found to be connected with the presence or absence of foods rich in uric acid and xanthin. If I assume he following table as fairly accurate it will be

seen that meat-eating and tea-drinking may be expected to cause constipation, and that such constipation can be cured in one or two ways.

1. Continue the dietary and give doses of certain alkaline salts (such, for example, as thialion), which act as uric acid solvents, and so undo the mischief which is being synchronously done, or,

2. Discontinue the dietary which is causing the mischief and substitute for it one which is not only uric acid free, but one which contains a high proportion of potassium salts (such as green vegetables), or,

3. Sufficiently reducing the amount of uric acid contained in foods without entirely abstaining from them, and increase the amount of potassium salt-containing foods without living entirely upon them.

By enjoying the third as the normal dietary and using the second as a curative dietary, I have been able to deal successfully—and by successfully I mean curatively for life—with a large number of cases that had hitherto been obliged to resort to the habitual use of purgative pills or salines to secure any regularity of defæcation. In cases, therefore, of chronic and obstinate constipation where I suspect the uric acid diathesis, and where, for example, the uric acid ratio to the urea rises in the urine above 1-30 for any long period of time, I cut off all flesh foods, restrict the eggs used to two per week; restrict the tea to twice a week (where I find it very inconvenient to cut it off entirely); give a fair proportion of milk and cereals, and give salads or conservatively cooked greens twice a day, and a *mélange* of fruit daily.

Let me in illustration quote one striking case. It was that of a young lady, *æt.* 20; she had always suffered more or less with constipation ever since her periods had commenced. During the last two years she had got much worse, during the first of these two years she had commenced to use enemata, and had carried this on as a regular practice; during the second of the two years the enemata had begun to lose their effect, and for a year and a half she had never in a single case had a natural motion. She then went under the Salisbury treatment, and was for some three months living upon chopped raw meat, hot water and dexterinised macaroni, and once each week she had a long tube passed and the lower bowel flushed out; the tube was said to be passed beyond the sigmoid flexure. When she came under my care she was very weak, suffering a great deal of headache, with nervous depression, and with, as I say, a constipation which had lasted the whole of this time.

I put her upon the dietary I have mentioned above, and was rewarded on my visit at the end of six days by the mother greeting me with the words, "Why a miracle has happened. My daughter has had a natural motion this morning."

This is now two years ago, and the girl from being a semi-invalid is fairly well, and again enters into the joys of life, while now natural motions always take place.

## THE RESPONSIBILITY OF THE MEDICAL PROFESSION

WITH REGARD TO

### PULMONARY TUBERCULOSIS. (a)

By NOEL D. BARDSWELL, M.D.,

M.R.C.P.Edin., M.R.C.P.Lond.,

Physician to the Deeside Sanatorium, Banchoy, N.B.

Now that considerable attention is being paid to the claims of the sanatorium treatment to be considered a cure for pulmonary tuberculosis, and in view of the very optimistic opinion held by a large section of the pro-

(a) Paper read at the British Congress on Tuberculosis, August, 1901.

fession and laity as to its possibilities as a curative agent, it is not inopportune to review briefly some aspects of the sanatorium question in its relations to these two sections of the community, and I will endeavour in the following paper to show to how great an extent the success of this treatment depends upon them, especially upon the former, viz., the medical profession.

On the strength mainly of statistics, published by various continental sanatoria, it is very widely held that such institutions should cure 80 per cent. of their patients, and probably this is not far from the mark—granting the "ifs" are met—and close analysis of statistics indicating 80 per cent. cures shows that there is indeed a very big "If" attached to them, viz., "If they are early cases." When this "If" is not forthcoming the figures are very different, as is well shown by the Görbersdorf Sanatorium statistics, for such cases, viz., 57 per cent. of the 1898 admissions, 80 per cent. of the 1897 admissions, and 94 per cent. of the 1896 admissions were dead. Doubtless many of these patients were discharged in a very much better condition than when admitted, many, indeed, with disease arrested, though only, as subsequent events showed, temporarily. These could have been fairly enough classified for statistical purposes as disease arrested, and to many the term arrest is synonymous with cure. Statistics as regards the sanatorium treatment will remain of comparatively little value until the terms used, such as "cured," "nearly cured," and "disease arrested" are very clearly defined. However, it is not my intention now to consider this question of statistics, but rather to show how the public and the profession can influence them for good or ill, inasmuch as it is they that supply sanatoria with the material from which their figures are ultimately compiled.

With a view to demonstrating this, I have made an analysis of the first fifty-six admissions to the sanatorium with which I am connected, attention being specially paid to the following points, viz. :—

1. The duration of definite tuberculous symptoms.
2. The treatment received since the probable diagnosis of the disease up till date of admission.
3. The condition of the lungs on admission.
4. The amount below the highest known weight on admission.
5. The amount of fever present during the first week after admission.

This analysis has brought out several points of interest as regards the attitude, both of the medical profession and the public, to consumption.

The following are the tables of the analysis :—

TABLE I.

Duration of definite tuberculous symptoms in all cases previous to admission.

Duration of Illness.	No. of Cases.	Percentage.
From 1 to 3 months ...	10	18
" 3 " 6 " ...	16	30
" 6 " 9 " ...	7	12
" 9 " 12 " ...	8	14
Over 12 (a) ...	15	27
	56	—

TABLE II.

Condition of the lungs on admission, classified according to the number of lobes diseased.

Number of Lobes Diseased.	No. of Cases.	Percentage of all Cases.
1 ...	2	4
2 ...	24	41
3 ...	10	18
4 ...	8	14
5 ...	10	18
With pleuritic signs only, but with bacilli in sputum ...	2	4
Total number of all fifty-six cases, with definite signs of excavation on admission ...	27	50

(a) This group includes six cases of recent relapse, following more or less complete arrest for several years.

TABLE III.

Amount below highest known weight :—

Number of lbs. below.	No. of Cases.	Percentage of all Admissions.
Up to weight ...	9	16
From 1 to 7 lbs. below ...	6	10
" 7 " 14 " ...	24	43
" 14 " 21 " ...	11	20
" 21 " 28 " ...	4	7
Over 30 lbs. ...	2	4

TABLE IV.

Amount of fever present during the first week after admission, calculated in each case from the highest points touched daily during the first week, the average being taken.

Degree of Fever.	No. of Cases.	Percentage.
Apyrexial, or very near it ...	21	38
Slight fever (above 98.6° at 8 a.m., but not above 100° during the day) ...	10	18
Moderate degree of fever (above 100° F. during the day) ...	13	23
Considerable fever (above 101° F. during day) ...	5	9
High fever (above 102° F. during day, or with inverse temperature at high range) ...	7	12
	56	—

A glance at this analysis shows that in each table there is one subdivision bracketed with much the highest percentage; these subdivisions, taking them *seriatim*, being (1) duration from three months to six months; (2) two lobes diseased; (3) seven to fourteen pounds below highest known weight; (4) apyrexia, or very nearly so.

Of our fifty-six admissions, then, cases which could be classified under a definition founded on the titles of these four subdivisions have been more numerous than any other type of case, and, along with the even more favourable cases of from only one to three months' duration, up to weight or but slightly below, and cases of quite recent relapse following long-standing arrest, account for some 60 per cent. of all patients admitted. It is from this 60 per cent. that we have to hope for 80 per cent. of cures. Of the remaining 40 per cent. of the admissions, it is seen that 21 per cent. had fever range above 101° F. during their first week after admission, this number including several about 102° F., some 30 per cent. had disease in either four or five lobes, and about the same percentage were anything from fourteen pounds to thirty pounds below their weight. With cases of this type it is idle to expect satisfactory figures, though, except when in an absolutely hopeless condition, even such may improve very considerably, gaining much weight and having the disease to a large extent arrested. Doubtless every year now will see a greater proportion of genuinely early cases sent to sanatoria, but in the meantime it is of interest to ascertain why it is that more of such cases—early in the pathological sense—are not seen in such institutions.

To throw light upon this subject I have closely inquired into the previous histories of all the fifty-six cases already referred to, and find that the majority of them can be placed in one of the following divisions, the delay in seeking efficient treatment being due either to themselves or to their medical attendants.

The following table is an attempt to classify the cases in this respect :—

#### PATIENTS THEMSELVES CHIEFLY RESPONSIBLE.

Group I. due to—

1. Long delay in taking medical advice, in the hope of throwing off the cold, &c.
2. Refusal to follow good advice, though quite able to do so, till frightened by onset of serious symptoms.
3. Delay in following good advice, on the grounds of expense; the sacrifice eventually being made when the chances of cure are considerably poorer.

## MEDICAL MEN CHIEFLY RESPONSIBLE.

Group II. due to—

1. True nature of disease not being diagnosed till it is far advanced. Such cases have usually been treated—often for a considerable time—for muscular rheumatism, anæmia, debility, chills, or influenza, &c.

2. Disease being diagnosed, but its nature concealed from the patient, who is informed that he has not got consumption, but a little catarrh of the lung, weak lung, tendency to consumption, a lung touched, or some such indefinite condition.

3. Disease being diagnosed, but apparently on the assumption that it is inevitably fatal, nothing but merely symptomatic treatment being adopted, until on the suggestion of friends or relatives the sanatorium treatment has been decided on as a last hope.

4. Disease being diagnosed, and, in many cases, at the request of patients or their families, sanatorium treatment at home having been tried without success.

In preparing these tables I have not considered the chronic cases of many years' duration, since their illness dates from pre-sanatorium days.

So much as to the reason why many cases do not reach Sanatoria early enough. Now as to the remedies:—

a. On the patient's side. Better knowledge on the subject of tuberculosis generally, and especially upon the value of early treatment of this disease. In this question of education the medical profession can do much.

b. On the part of the medical profession. In a paper of this length, I can only deal with the first two items on my second list of causes.

First: as to that of failure to diagnose the disease in the early stage, and sometimes, indeed, in a fairly or well-advanced stage. Granting that physical signs of early phthisis are often very slight or very indefinite, and that early symptoms are so insidious that it is often difficult to say when a condition of poor general health ended, and tuberculosis began, there remains little or no excuse for a case being allowed to drift into a condition of well-marked disease, with such a certain and easy method at hand for establishing a diagnosis, as the examination of the sputum. I have heard it urged that medical practitioners have something else to do than systematically look for bacilli in all their suspicious cases; but with the facilities now offered for this purpose by public authorities and various associations, such a procedure is quite unnecessary. I feel convinced that systematic examination of chests and sputum, of cases who seem to be just run down, and out of health with no very obvious cause, would in many instances lead to an early diagnosis of hitherto unsuspected tuberculosis. It is more difficult to account for cases under medical supervision running into an advanced stage of the disease, even a stone or more below weight, before the condition is recognised.

Hurried and too superficial chest examination, the outcome of overwork, is no doubt responsible for some of it. The worst disclosure of all which may be revealed by a study of a consumptive's previous history, I have fortunately not come across since giving up hospital appointments, viz: that the chest had never been examined except through clothes.

Upon the question of wilfully hiding the truth from patients, and substituting such terms as weak lungs for the true name, there is doubtless much diversion of opinion. The word consumption certainly has as yet lost but little of its ill omen, and it is very striking how studiously sanatorium patients avoid using it. More than one of such patients have told me that they had received quite a shock soon after admission, by hearing some older hand talking calmly about consumption, *a propos* of themselves. Still, however unpleasant the duty may be of telling a person that he has consumption, I have personally no hesitation in saying that in the great majority of cases it is a duty. In very many instances, when the truth is concealed, the patient continues work, and takes but little notice of medical advice, good enough in itself, but not sufficiently insisted upon until subsequent events show him that he has been living in a fool's paradise. In my own experience I have met with many patients with advanced disease, who have remarked: "If only I had been told

the truth earlier, how differently would I have acted during the last six months." Making all allowance for the factor of wisdom after the event, I feel sure that in nearly all cases, honesty, as regards this question, is the best policy—alike for patient and medical man.

## PHARMACY AND MEDICINE. (a)

By ARTHUR P. LUFF, M.D., B.Sc., F.R.C.P. Lond.,  
Physician and Lecturer on Forensic Medicine in St. Mary's Hospital.

It is twenty-seven years since it was my good fortune to be a student in this school, and I know of no greater honour and no greater pleasure that can be conferred by one's alma mater than for one of its alumni to be entrusted with the duty of delivering this annual address. The occasion is moreover a pleasant and an auspicious one, since this year marks the sixtieth anniversary—the diamond jubilee—of the Pharmaceutical Society.

Pharmacy is a many-sided calling, and therein undoubtedly lies one of its chief attractions. The scientific part of the work of an educated pharmacist does not consist solely in the dispensing of prescriptions, important as that branch of his calling undoubtedly is. We hold him to be the responsible person for the preparation of drugs in suitable forms, and for the standardisation of those preparations, while the public have to look to him not only as providing means for the restoration of their health, but also have to rely upon him for the safety of their lives. It is but a pessimistic and ignorant view to take that no great amount of skill or of scientific training is required to put together the ingredients of a prescription. Such a view does not recognise, and perhaps the public do not adequately appreciate the great safeguard to them that the educated pharmacist is. It is no very uncommon matter for the medical man when hurriedly writing a prescription to make such a mistake in the dose of an important ingredient that disastrous results to the patient would follow the taking of the medicine if so dispensed; but now, happily, through the far-sighted wisdom primarily of this society, and subsequently of the legislature the public safety is efficiently provided for. The pharmacist detects the error in the prescription, and communicates with the medical man. The public are unaware of the means by which their health and possibly their lives have been protected, but how many of my professional brethren have to gratefully and thankfully acknowledge the tact, courtesy, and delicacy with which their attention is drawn to their mistakes by their pharmaceutical *confères*. Again, it is no very uncommon matter for a prescription to contain such incompatible ingredients that perhaps the active, and, maybe, poisonous principle of the medicine is wholly precipitated, and so might possibly be entirely taken in the last dose, with results which would probably be disastrous to the patient; but here again the skilled pharmacist acts as a guardian of the public safety by detecting and pointing out the error that has been committed.

But, unfortunately, both medical men and the public are tending to heavily handicap the pharmacist in that important function, and are in great part rendering him impotent to safeguard the public health, for there is a growing practice which is rapidly threatening to undermine to a great extent what I consider to be the skilled and rational employment of therapeutic agents in the treatment of disease. I refer to the too general use of powerful drugs in compressed forms and of proprietary preparations. I do not for one moment wish to suggest

(a) Abstract of address delivered at the Pharmaceutical Society of Great Britain on October 1st, 1901.

that tablets and other forms of compressed drugs have not their proper uses—undoubtedly tablets of certain active principles in the hands of medical men are most convenient and useful for hypodermic and occasionally for other forms of administration—but it is the ready facility with which powerful drugs prepared in this form are obtained by the public which constitutes so grave a danger, a facility which is responsible to a great extent for the increasing practice of self-drugging—a state of affairs which I am afraid has been brought about by these preparations being so indiscriminately and so largely prescribed by medical men. To take but one instance, it is to the ease with which tablets can be purchased by the public that, in my opinion, is due in great measure the prevalence of the comparatively modern and excessively pernicious evil—the cocaine habit. Equally bad is the use of some of the proprietary preparations which are so speciously puffed; with the samples and laudatory advertisements of which the members of my profession are so profusely deluged, tempting them, as they do, to the slovenly and enervating habit of thinking that the writing of an order for such a preparation is the writing of a prescription, and gradually rendering them absolutely impotent to exercise the true art of prescribing. Many of these tablets and preparations are, I believe, productive of infinitely more harm than the quack medicines which to some extent they are replacing, for the former are frequently powerful and, in unskilled hands, dangerous drugs, whilst the latter, though generally worthless, are to a great extent innocuous.

The fact is that the art of prescribing—that is, of ordering suitable remedies in suitable forms for the treatment of morbid conditions—is declining: it shows a fatal tendency to be usurped by the manufacturer. I am bound to confess that the primary cause of this evil is due, not to any imperfections in the training of pharmacists to scientifically compound and dispense medicines, but to the altogether inadequate attention which is given to the teaching of prescribing at so many of our large hospitals and medical schools. I merely refer to this phase of the subject here, as I intend shortly to deal with it in another place, and before those who are more closely interested in the preservation of this important branch of a medical man's duties. What a travesty on the art of prescribing it is for a patient to bring to a pharmacist a so-called prescription which merely orders, say, No. 4 mixture (Smith and Jones)! Can anything be more degrading than to compel a scientifically-trained pharmacist to be the mere medium for the handing over of such a proprietary article? Can anything be more degrading than the spectacle of a duly qualified medical man lowering himself to be the mere exploiter of a puffed and probably over-vaunted preparation? It appears to me that such so-called prescribing is nearly on a par with the dosing that is carried out on those ships which carry a medicine chest, but have no surgeon on board. The bottles of medicine in the chest are duly numbered, and with them is a book describing the symptoms which require a dose of such and such a numbered mixture. Many of you may remember the tale of the ship's steward who went to the captain stating that a sailor had some symptoms which, according to the book, required a dose of No. 9 mixture, but that No. 9 bottle was empty. "That does not matter," said the captain, who in the emergency almost rose to the level of a modern prescriber, "give him equal parts of No. 4 and No. 5."

In connection with my special department of practice as a physician I am brought in contact with only too many cases of self-drugging by the public, and only too frequently witness the evils rising

therefrom. Especially does one see this in connection with the worship of that absurd fetish, the uric acid diathesis, and the consequent pandering to this modern craze by the unscrupulous vaunters of the many puffed remedies which are warranted to sweep away what is but a natural constituent of the human body. That absurd craze is fostered, if not frequently originated, by the specious advertisements of drugs warranted to cure ills ignorantly, if not falsely, attributed to uric acid. The consequence is that it is now no uncommon sight at a dinner-party to see neurotic young men dropping their lithia tabloid into the glass of champagne to counteract what they imagine to be its acidity, lacking as they do both the gastric vigour to deal with the wine, and the moral vigour to abstain from it. I venture to sound a note of warning, which I trust may reach beyond these walls to the ear of the public, as to the danger incurred in dosing themselves with these powerful drugs in tabloid form—a danger which is in no sense an imaginary one, since we too often see the pernicious effects resulting from their indiscriminate use, sometimes, alas, when it is too late to remedy the evil results.

In conclusion, gentlemen, let me beg of you to remember that in joining this school it is your duty to endeavour to maintain its honourable traditions. Each one of you should strive to render yourself worthy of the high standard of education that has always been maintained here; each one of you should endeavour to emulate the examples of industry, perseverance, and success that have been set you by so many of your predecessors. When you think of the honourable positions in pharmacy that have been reached by so many past students of this school, when you recall the names of such men as Bentley, Atfield, Carteghe, Hanbury, Hills, Martindale, Allen, Umney, Greenish, and Squire, surely with such examples of successful work and perseverance you should have the strongest stimulus to follow their examples; also, I trust, to achieve their deserved success. The education that you will acquire here, although it will well enable you to pass your examinations, is not to be regarded as serving that purpose alone. Look on it as a talent entrusted to your keeping for your future use. Be careful that you do not, like the slothful servant, keep it laid up in a napkin, but see that you so utilise it as to increase it, if possible, tenfold.

"Strive, endeavour; it profits more  
To fight and fail than on Time's dull shore  
To remain an idler ever.  
For to him who bares his arm to the strife,  
Firm at his post in the battle of life,  
The victory faileth never."

## MEDICINE AS A PROFESSION. (a)

By PROFESSOR RISIEN RUSSELL, M.D.,  
F.R.C.P.,

Assistant Physician, University College Hospital, &c.

AFTER welcoming the students and insisting on the importance of their becoming "good, all-round men," the lecturer pointed out how essential a knowledge of bacteriology had become to the medical man, and how chemistry, always a most important subject in the medical curriculum, had acquired additional importance since a knowledge of chemical methods had become so necessary to the bacteriologist. Chemistry had also become more important because chemical analyses of the blood, the excreta and the contents of the stomach were now indispensable in the diagnosis, prognosis, and rational treatment of many diseases.

(a) Abstract of Introductory Address delivered at University College, October 1st, 1901.

He next called their attention to the special advantages there were in entering the medical profession at the present time. No other profession could hold out the prospect of so quick a return on the outlay that students were obliged to make. In support of this view he pointed to the fact that during the last seven years there had been a falling off in the number of men entering the medical profession, so that there were now 1,660 fewer men qualified to practice medicine than there would have been had the same number joined the profession each year since as did so in 1893. In the meantime, as the figures of the last census showed, the population of the country had increased to the extent of over three and a half millions during the last decade. The colonies had always supplied many good openings for men who had received their medical education in this country, and they might be expected to continue to do so; but to South Africa more especially he felt justified in looking for a large number of openings for young medical men when the development of the country was proceeded with after the termination of the war. Then again the vigorous and laudable action of the General Medical Council in suppressing unqualified assistants and in stamping out the iniquitous system of "covering," had made many openings for qualified men. The expert committee appointed under Mr. Brodrick's presidency had been an earnest of the Government's determination to reform the Army Medical Service. The scheme for the reorganisation of the service was now said to be ready, it had been passed by the Treasury and only awaited the signature of the King. There was ample evidence to show that the Admiralty would have to follow the example of the War Office and institute reforms in this branch of the service.

Reforms in the medical services of the Army and Navy would not only provide good openings for young medical men, but as more men were attracted by the Services those available for the civil population would be reduced, and the chances that a young man would have of making his way in private practice would thereby be greatly improved. How small was the reserve of young medical men, even at the present time, had been demonstrated by the experiences connected with the South African war, for those required for the Army had not been supplied without inconvenience in other quarters. Provincial and other hospitals had had difficulty in securing men to fill posts as house physicians and house surgeons; steamship companies had experienced a similar difficulty in getting medical officers; and many medical men in general practice had not found it easy to take a holiday this year, either because it had not been possible to obtain locum tenentes or because the remuneration such substitutes now received was more than many practitioners could afford to give. These various considerations led him to conclude that the medical man who was ready to practise his profession in five or six years' time would be in a most satisfactory position, so that students now commencing their medical studies could look forward to finding openings for the practice of their profession five years hence with a degree of certainty that did not obtain in any other profession.

He complained of the unsatisfactory public status of the medical profession, which he attributed, in part, to the way in which some of its members deported themselves, even where they occupied high professional positions. Another reason why the profession did not rise to its proper level in public estimation was the difficulty the public appeared to have in distinguishing between the medical man of the present day and the apothecary of the past, probably because so many medical men still dispensed their own medicines. He recognised the difficulties that

would have to be contended with in many an out-of-the-way part of the country were doctors not to dispense their own medicines; but such cases were in the minority, and the majority of medical men in private practice could discontinue dispensing medicines with the greatest possible benefit to themselves and to the public. The time now spent in doing druggists' work could be utilised to far greater advantage to themselves and to their patients if devoted to reading to keep themselves informed of the advances that were constantly being made in every branch of medical science, abolition of the practice would help to educate the public to regard the medical man as something superior to a mere vendor of drugs, and would teach them to value him for his advice instead of for his medicine.

The lecturer then discussed the influence of University College on medical teaching, observing that the influence which University College had had on medical teaching in London was very great, the scientific education received at the College being unsurpassed by anything that could be obtained elsewhere in this country, and the spirit of scientific research that was active had led to brilliant achievements by those who had worked there, and by others who had gone forth to prosecute their researches elsewhere.

He begged his hearers to cultivate the spirit of scientific inquiry, which, properly conducted, might be expected to disclose some new fact, and this was the only way in which true progress could be made. Medicine and surgery could only be expected to be advanced by a proper commingling of the scientific and the practical, so that scientific principles might find practical application in the elucidation and treatment of disease. If they required any stronger incentive to induce them to aim at being able some day to advance the science of medicine by their own investigations, let them read of the horrors of surgery in the days before antiseptics were introduced in the treatment of wounds, and compare that picture with what they saw when the time came for them to take up their duties as dressers in the wards of the hospital connected with the College. He would be surprised if the contrast between the two pictures did not stimulate them to emulate the example of men like Pasteur and Lister, even though they felt mere pygmies compared to those giants. Well might Lord Lister ignore the vituperations of a gang of agitators who, in the face of such an incalculable benefit as he had conferred on his fellow-beings, dared to treat him to some of the abuse that they visited on all those who by their researches sought to investigate the sum total of human suffering.

## Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, September 29th, 1901.

### ENURESIS IN CHILDHOOD.

THE difficulty often met with in the treatment of this complaint renders the subject one of considerable interest. A paper on the subject appeared in a recent number of the *Berl. Kl. Wochensch.*: (31/1901) from the pen of Privatdocent Dr. Thiemich. The writer designates the condition as a form of incontinence of urine in which the urine is passed without the knowledge or against the will of the patient. It may be due to a demonstrable affection of the urinary tract, or to a severe affection of the nervous system, or to general illness in which consciousness is interfered with. What is generally understood by the term is a more independent lesion of which the functional disturbance is

the only symptom. In infancy enuresis is physiological, and the condition later on is a frequent symptom of imbecility. One of the symptoms of the backward development of the child. Sometimes it is due to careless bringing up and training as to cleanliness, so that it need not necessarily be considered as pathological if continued after the third year. The attention of the physician is demanded when it recurs in a child who has already kept himself dry at night.

Most of the children suffering from enuresis are the offspring of neuropathic parents. Two causes participate in bringing about the condition, first, the hereditary tendency inherent in the offspring from marriage of neuropathic parents, and, secondly, imperfect training. Not unfrequently it may be ascertained that one of the parents suffered from such a condition. In many children who have suffered from enuresis or been cured of it symptoms of hysteria develop. A proof of the hysterical complication is the epidemic form of the affection that sometimes breaks out in schools, institutions, &c. The disturbance ceases as soon as the affected children are isolated. Perfectly healthy children do not fall victims to this imitation of disease. Those who do so are all neuropathic or hysterical. The remedies that have been found useful in hysteria are just the ones that prove serviceable in enuresis, and *vice versa*.

The *Korr-Bl. f. Schw. Arzt* has an article on the

#### FATE OF HEREDITARILY SYPHILITIC CHILDREN,

by Dr. J. Karcher, Bale. Of thirty-one children treated between the years 1876 and 1896 and discharged as cured sixteen were traced. Six died as small children; four were found to be perfectly sound after reaching the time of puberty. It was known that one other was a workman in a factory. Five children later on became infected with tubercle. The fate of syphilitic children is not so desperate as some would imagine. The article, taken in conjunction with the works of Hochsinger and Pott, shows many children lose all signs of the disease after puberty. It shows also that inunction treatment with yellow ointment is useful not only as regards evident symptoms, but also as furthering good results in later life.

#### PURE CARBOLIC ACID IN SEPTIC WOUNDS.

Dr. B. Honsell, of Tübingen, has an article on this subject in the *Bertrage z. Kl. Ch.*

The author says it is known that many surgeons have given up the use of pure carbolic acid in the treatment of wounds on account of the great risks accompanying it. An American surgeon, Phelps, has recently tried to reintroduce it. After a wide opening into the abscess cavity or the joint the part is cleansed by curettement or other means, the cavity is then filled with pure carbolic acid, which is allowed to remain for one or two minutes. It is then thoroughly washed out with alcohol. Into the wound so prepared a thick glass drain is inserted and tamponnaded. This is allowed to remain until granulations have formed. When this treatment was introduced morbus coxæ was the disease for which it was first proposed. The fact that such a large cavity can be treated in such a way with pure carbolic acid is one that calls for consideration. It is claimed that the treatment described is superior to any other.

In the Tübingen Klinik the plan has been followed under the direction of von Bruns. Eighty cases were treated in this way. More than three-fourths of the cases were acute or subacute affections. V. Bruns varied the procedure laid down to some extent.

After preliminary purification of the wound, curettement or excision of the diseased parts, the whole region around was thoroughly moistened with alcohol to prevent any caustic action on the epidermis. The carbolic acid (at most 6 grms.) was applied by means of pledgets of lint. The wound, after the carbolic has been allowed to remain a couple of minutes, is thoroughly washed out with absolute alcohol. Finally, the wound is packed with either sterile gauze, or airol, or iodoform gauze strips, or more rarely moist dressings. The most suitable dressing has been shown to be a layer of antiseptic gauze, and then packing with aseptic pads. No great pain was observed at any part of the proceedings, on the contrary, pain was often relieved, possibly through an anæsthetising action of the carbolic acid. One could not resist the impression that the carbolic dressing did good. Only once was any disturbance set up, and that was in a case of very malignant traumatic suppuration of the knee-joint with abscesses in the adjoining parts. Fresh suppuration came on, and the wound had to be re-opened. All the other cases recovered quickly and simply. No retention of pus was observed under the tamponnade, even after several days. The tampons were allowed to loosen themselves from the side of the abscesses. A second or third tamponnade was necessary in only a few cases. In tuberculous suppuration the procedure is recommended in cases in which the mixed infection is marked. The curette is a necessary adjunct to the treatment. An attempt was made to treat simple abscesses by aspiration and injection of carbolic acid, but incisions had to be made later in all cases. This showed that the slough caused was not absorbed, but remained in the cavity as a compact mass.

## Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, September 28th, 1901.

#### THE ACTION OF DIGITALIS.

DIGITALIS is one of those drugs which have given rise to endless controversies, not even excepting the latest Congress, with all our experimental science and exact methods of measurement and testing as final proof one way or another. Gottlieb commences his paper with the usual postulate, "all disturbances of the circulation must be due to some pathological changes either at the heart or vasomotor centres, or it will soon return to its normal condition if not interfered with.

If the innervation of the vasomotor fail the internal organs become filled, while the surface becomes pale and bloodless; the pulse is small, the heart being imperfectly filled. If this failure of the innervation arise from narcotic agents or infectious poisons cardiac drugs are of no use, as it lacks not in functional activity, but rather in material to operate upon which has accumulated in the internal organs. It is very different when the vasomotor and splanchnic vessels are stimulated.

Hence life may often be saved, not by giving digitalis, but by the use of strychnine, caffeine and camphor, as



well as friction of the skin and cold applications as analeptics. Digitalis increased the volume of pulse and may raise the force of the ventricles and auricles four-fold. The drug is indicated therefore when the pulse is slow and feeble. This will empty the cardiac chambers and permit of an easy inward flow from the veins during diastole. The vascular emptying of the liver, lungs, &c., is best performed by vasomotor stimuli, such as camphor. Caffeine acts on the heart, but is no substitute for digitalis. Alcohol is another agent which relieves the resistance of the heart by dilating the vessels.

Sahli considers that diagnosis is an important factor in prescribing digitalis. He is inclined to divide it into (1) congestion of the cardia, where the systole is insufficient to empty the heart and thus produces a mechanical barrier to the inflow of blood during diastole; (2) respiratory congestion, which may be the result of the former or due to some other mechanical cause; (3) vasomotor origin, owing to paralysis of the vasomotor nerves.

Digitalis, he affirms, is as useful in the high pressure artery as in the low pressure. The former will come down, the latter will rise after its administration. It may even prove a curative agent in the so-called compensation state, when the "circulus vitiosus" is often checked for years. In "essential" congestion of the heart, or in those cases where the valves are so much damaged as to allow regurgitation after the systolic contraction, little or no good can be obtained from digitalis; indeed, many serious results are recorded that have not infrequently brought opprobrium on the drug.

He next drew attention to the importance of the dose; the large dose for the diastolic effect, and small doses for systolic action.

As to the length of time it should be used, this, he said, was very indefinite as many patients could tolerate it for years.

Caffeine and camphor were very different drugs. In vasomotor disturbances where dilatation was prominent these drugs were excellent stimulants. Sahli considers them potent adjuncts to digitalis, in respect both of breathing and urine.

Alcohol hitherto stands unsupported as a cardiac tonic, but may relieve the heart in high or normal pressure congestion, but on account of its fugitive action no reliance can be put on it. In acute fevers it may be viewed in the same light as of very little use on the circulation, unless in the rigor stage or after a cold bath, when it may be administered with considerable advantage.

Schott contended that the firmer the contractions of the heart the better it was for the vasomotor action. Camphor, he thought, had but a feeble action on the heart.

Jacobs agreed with Sahli that digitalis in aortic insufficiency fails to give relief because the muscle of the heart is already strained to its utmost, and can not be further stimulated to action as the digitalis acts through the vagus.

Lang thought the variety of opinions in the profession was due to badly made preparations of the drug, and thought there would be less disappointment if the infusion was always administered.

The stimulating action of digitalis can be increased by the addition of camphor and alcohol.

Heinz was in favour of using fine powder rather than bruised leaves for making infusions.

Goldschneider recommended 0.1 to 0.2 gramme of digitalis for a month in compensation disturbance, to be repeated a week after.

Hirsch gave his experience of the internal friction of the blood, or what he terms its active "viscosity."

The specific gravity of the blood and this viscosity do not run parallel. Again, he finds this "viscosity" is not confined to the corpuscular elements of the blood but is also found in the serum.

The hypertrophy of nephritis is not confined to the left ventricle, but invades both. The cause must therefore be either a direct irritation of cardiac muscle or an increased viscosity of the blood.

Ewald remarked that large doses of digitalis were often given in cases where the whole vascular system was loaded with fluid. The first duty is to relieve the vessels by puncturing the tissues, scarification, or by Dehio's modification, which is by inserting a gum apparatus. All cardiac drugs affect the stomach, and for this reason he recommended enemata or suppositories of digitalis or adonis vernalis.

Pick thought that digitalis was sufficient to produce the necessary contraction of the vessels to prevent oedema. For himself he had more faith in hydrastinin for bringing about contraction of the peripheral vessels.

Unverricht blamed the digitalis preparations for the difference of opinion. If Golas's dialysate were used this would be avoided, but it was much more satisfactory to use digitoxin. Digitalism and anorexia were as common when enemata were used as when the drug was given by the mouth. The cause of the disturbance was central and not local.

Rosenstein was in favour of strophantus as being superior to digitalis, in that it produces no anorexia as does digitalis. As for camphor, its action was too evanescent to be of much use in cardiac affections. When asked if he thought the production of an anæmic murmur was due to changes in the blood, he assented but added that "viscosity" of the blood was not the cause of the hypertrophy.

Naunyn had faith in digitalis, but in digitoxin he had none. The anorexia could be obviated by giving small doses, which can be given for a long time without fear of digitalism.

Grodel said it was impossible to preserve the life of the patient by the continuous use of digitalis, but his life might be prolonged.

Rosenfeld said he had returned to the use of an infusion of digitalis as the best way of giving the drug; digitoxin was of no use. The active principle was in the stems as well as the leaves, which should be used entire. To get the best effects from adonis vernalis it should be made in the form of tea and one tablespoonful to a teacupful should be taken twice a day.

Schreiber thought the method of measuring "viscosity" in blood might be useful in the pathogenesis of uræmia, &c., but was inapplicable in the event of hypertrophy.

THE Council of the South Wales and Monmouthshire University College are advertising for a successor to the late Principal Viriamu Jones at a salary of £1,000 per annum.

## The Operating Theatres.

### GUY'S HOSPITAL.

OPERATION FOR OLD-STANDING FRACTURE OF FEMUR.—Mr. ARBUTHNOT LANE operated on a boy, *æt.* 16, who had sustained a fracture of the femur about five months previously, for which he had been treated at first by recumbency and extension, and lately by a Thomas's splint. It was only after a very long interval of time that he was able to get about at all, and then only very insecurely because of the very imperfect union of the fragments and of the considerable shortening of the limb. Owing to some sudden movement he lost what little power he had in the leg, the fragments moving freely on one another. He then came under Mr. Lane's care, when a radiograph showed that the ends of the fragments, which overlapped considerably were rounded, and there was no sign of intermediate callus. A long incision was made along the outer aspect of the thigh, and the fragments freely exposed; the incision was made in this locality, Mr. Lane said, so as to reduce the damage to nerves and muscles to a minimum, also because a larger incision could be made in this situation than in any other, and the fragments were more readily approached, exposed, and dealt with from this aspect than from any other. The conditions found were as shown in the radiograph, a scanty amount of imperfectly calcified connective tissue being the only evidence of any union between the bones. The fragments were freed from the soft parts, and were protruded through the wound, every precaution being taken against their touching the surrounding skin. It was hardly necessary, Mr. Lane thought, to point out that under no circumstances in these operations are the fingers introduced into the wound, all the work being done by means of instruments. He is convinced that it is owing to the gross carelessness of surgeons in fouling such wounds by the introduction of their fingers into them that they are unable to employ a screw or other bulky medium as an efficient means of establishing union between the fragments; that it is a common habit to use fingers in this dangerous way, he remarked, was shown in many illustrations of operations in recent publications, and as long as this is persevered in, and only a very modified *sepsis* obtained, the results will continue to be unsatisfactory. An examination of the fragments showed that while the texture of the lower one was fairly normal and of a sufficient density to hold a screw that of the upper was exceedingly unsatisfactory, so much so that its section with a saw in order to afford accurate apposition of oblique surfaces was accompanied with a certain amount of comminution; in fact, it was so fragile that it seemed as if it would be impossible to connect it to the other fragment by any means short of a *ferule*, and such an implement was not obtainable at the moment. After a time, however, the operator succeeded in retaining the fragments in apposition by means of a wire which perforated both fragments, and of several wires which surrounded them. He remarked that he had on several occasions observed this rapid degeneration of the upper fragment in a fracture of the femur in this situation in children in whom a considerable interval of time had elapsed between the receipt of the injury and the operation, and in one case especially, the fragility of the

upper fragment was so extreme that by no means was it possible to connect the fragments together. Why there should be such a considerable difference in the behaviour of the two fragments of this bone does not, he thought, seem quite clear. The wound was closed and the patient placed in a double Thomas's splint. A fortnight after operation the progress made by the boy is most satisfactory.

The next case was that of a man, *æt.* 61, who had sustained two months before, a spiral fracture of the femur, and had been treated by recumbency and extension; no union whatever had resulted. A radiograph showed that the fragments were not in apposition, and that they overlapped very considerably. They were freely exposed through a long incision, when the upper fragment was found to be displaced upwards, forwards, and outwards, and the lower downwards, inwards, and backwards, the direction of the planes of the chisel-shaped ends of the fragments accounting for the direction of the displacements. Although a considerable interval had elapsed since the receipt of the injury, the outline of the fractured surface was unchanged, it being covered only by a layer of soft fibrous tissue, which was easily separated from it. When this had been done the length of the fracture was seen to exceed four inches, and it was possible to fit the sharp summit of each fragment into the corresponding angle of the other; the bones being retained in this position, two stout virgin silver loops were introduced through the fragments in such a direction as to afford a maximum of resistance to any tendency to their separation resulting from a torsion of one upon the other. The reason, Mr. Lane said, a screw was not employed in this case was because of the extreme narrowness of the spikes of bone, and it was felt that in this particular fracture wire inserted at suitable angles would afford a firmer apposition. The condition of the limb during the fortnight that has ensued since the operation has been most satisfactory.

FRACTURE OF BOTH BONES OF THE FOREARM.—The same surgeon operated on a boy, *æt.* 10, for fracture of both bones of the forearm about their centre. The injury had been sustained several months before, and the union had taken place, so that the axes of the fragments formed a considerable angle with one another, and the range of pronation and supination was exceedingly limited. On account of this, as well as of the deformity of the arm, the parents were anxious that something should be done. The junctions of the fragments were exposed, and were divided by means of a saw, each in two oblique planes, so as to restore both bones to their normal form and relationships. The fractures were united together by loops of silver wire which perforated them. Mr. Lane said that a similar case had been published in "Operating Theatres" in January last, and in this the result has been perfect, the boy having at the present time full and natural use of his limb. The present case three weeks after operation is progressing satisfactorily.

A MEETING in support of Dr. J. G. Glover's candidature for the General Medical Council will take place on Friday, October 4th, at the residence of Dr. White, No. 1, Highbury Place, N., in which Sir Thomas Barlow, Dr. Danford Thomas, and others will take part.

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"SALUS POPULI SUPREMA LEX."

WEDNESDAY, OCTOBER 2, 1901.

**HELP FOR THE TUBERCULOUS POOR.**

ONE of the great problems in connection with the eradication of consumption is unquestionably the provision of sanatoria for the tuberculous poor. This pressing and all-important question has been raised *de novo* in *The Times* by two admirable letters from that veteran sanitarian, Sir John Simon, and by the equally illustrious physiologist, Sir John Burdon Sanderson. Sir John Simon's contention is that "the provision of sanatoria is an indispensable part of the measures necessary for the diminution of tuberculosis," in the terms of the resolution passed by the recent Congress. Addressing himself to the question how these sanatoria are to be provided, he urges that it is the duty of the local authorities to raise the necessary funds, if need be, by an addition to the poor rates. He pleads that any addition to the rates, and it would have to be considerable, would be more than counterbalanced by the gain to the public health and the avoidance of the incalculable loss of health and working energy resulting from present conditions, under which the working man who develops tuberculosis is almost of necessity condemned to permanent invalidism and ultimate death. No one with any knowledge of the subject would deny that accommodation for the tuberculous poor is ridiculously inadequate. What the working man requires is not merely medical relief but to be enabled to regain his lost working power, a result which cannot be achieved by the administration of any kind of drug or remedy but by rest, moderate exercise, good air and good food. The only way in which a chance of successfully struggling with his malady can be given him consists in enabling him to free himself for a sufficient time from the conditions of life and occupation which are detrimental to his well-being and favourable to the progress of the disease. We must look matters boldly in the face. We must

recognise that there is practically no hospital accommodation for the tuberculous poor, for the very limited number of beds available in special institutions can relieve but an infinitesimal fraction of the sufferers, and such cases cannot, for obvious reasons, be admitted, or at any rate retained, in the general hospitals. Moreover, as has already been pointed out, it is not so much hospital treatment that is required, but transference to healthier conditions. As Sir J. Burdon Sanderson says, the object before us can only be attained by the establishment and maintenance of frugally organised sanatoria for bread winners of both sexes. Houses of recovery must be provided in healthy situations not too far removed from industrial centres, where working men and women threatened with phthisis may obtain such moderate accommodation as they require. Admission must be free to those who are socially and medically eligible, and the number of beds must be sufficient to render possible the prompt admission of all who require it. The very magnitude of the task is calculated to make the public look askance at the proposal, yet many years ago the community approved almost as great a departure in the endeavour to stem the ravages of small-pox, a disease which was, even then, far less deadly in its incidence than consumption. Subsequent experience has endorsed this huge expenditure of public funds, and the example may serve to encourage those who, while they deplore the present condition of things, lack the courage to initiate the steps by which alone real progress can be secured. The matter is too vast and too urgent to be safely left to private benevolence, and it may well come to pass that the nation, as ratepayers, will consent to assume this additional burden in aid of the suffering and less fortunate members of the community.

**THE SMALL POX EPIDEMIC IN LONDON.**

THAT London is now faced with a serious epidemic of small-pox must be apparent to all who are familiar with the history of that malady. The gravity of the situation is shown by the fact that the cases hail from all quarters of the metropolis, and in that way point to a wide distribution of centres of infection. It is natural that under such circumstances the popular interest has been aroused with regard to the value and desirability of vaccination as a preventive measure. On the whole the result has been satisfactory as regards the general adhesion of the populace to the beliefs of orthodox scientific medicine upon that particular point. During the past few weeks an enormous number of citizens of all ages, ranks, and conditions have submitted themselves to the not very formidable ordeal of vaccination or re-vaccination. This wholesale submission in the face of impending danger points to the fact that the main masses of our countrymen are favourable to vaccination. In spite of the general attitude, however, there can be no doubt that the outlook is such as to demand our most careful and serious attention. There is, and always has been, for instance, a great

margin of unvaccinated persons in the metropolis; in other words, there exists in the midst of the huge congregation of Londoners a great mass of inflammable material, ready to light up at the first approach of small-pox, which is one of the most infectious of maladies. That fact, as we have persistently maintained, will sooner or later be blazoned forth by a disastrous invasion of one or other of the notoriously unprotected districts. In Mile End, for instance, the anti-vaccinationist attitude of the guardians, who have for many years refused to prosecute for failure to vaccinate, has given rise to a large unvaccinated population. That district, as matters stand, is a standing menace to the safety not only of its own inhabitants, but also of the metropolis generally. Unfortunately, the leaven of the anti-vaccinationist heresy is widely spread. The London School Board has given a feeble and half-hearted response to the appeal to help the public health authorities in their attempt to carry out vaccination to the utmost among the scholars. The attitude of the School Board is a faithful reflection of the retrograde Vaccination Act that has established the permissive principle in its administration. It is difficult to understand how a man of Mr. Balfour's intellectual calibre could have believed that his concessions, however ample and reactionary, would permanently satisfy the noisy crew of anti-vaccinationists. In Eastbourne they have gone the length of issuing certificates of exemption signed by guardians instead of by magistrates. The proceeding, if we mistake not, is a direct contravention of the Act, and will doubtless prove a subject of inquiry before the higher courts of law. It requires no great experience of the methods of the anti-vaccinationist to recognise that he is of the temperament that demands an ell where he has been granted an inch. That aspect of his character, however, seems to have escaped the purview of Mr. Balfour's Government, who gave him the inch with a vengeance when they brought into being that monstrosity, the "conscientious objector." Before that worthless sop was thrown to the anti-vaccinationist elector the margin of children in London "unaccounted for" in respect of vaccination amounted to no less than a quarter, or one-third. That statement is made on the strength of returns issued by the Local Government Board. In Bethnal Green there were 71.7 per cent. unaccounted for, 70 per cent. in Hackney, and 67.4 per cent. in Mile End Old Town. Those figures will naturally be swelled by the operation of Mr. Balfour's Act, which we have all along predicted simply awaits the Nemesis of a vast epidemic. That event may or may not be at hand, but in any case we regard it as absolutely certain sooner or later to overtake the unprotected population. It is like the voice of one crying in the wilderness to utter warnings to the antivaccinationists. At the same time we venture solemnly to recall the following facts. During the period 1847-1853, when vaccination was optional, the mean annual death-rate per

million at all ages amounted to 305. From 1854-1871, when vaccination was obligatory, but inefficiently performed, the rate sank to 223. On the other hand, during the years 1872-1891, when vaccination was better enforced, the mortality fell to 89. Could any stronger argument be brought forward? The enormous saving of life has been among the children, for during the first period mentioned above the death-rate under five years was 1,617 per million living; during the second 817, and the third 177. Those who love children, therefore, and wish to save them from a miserable death by small-pox, could not adopt a more absolutely sure means of securing their safety than by having them vaccinated. Meanwhile the enemy is within the Londoners' gate.

#### METHYLATED SPIRIT.

SOME few years ago the medical profession were alarmed by the report that essence of ginger produced blindness, and as a consequence a valuable and tried carminative fell into disrepute. After a time equally bad reports came of other flavouring essences, in all cases the sight being affected. In some cases death followed, the lethal effects being found to follow the many compounds placed on the market to give the flavour of old whiskey to raw cheap spirits. The whole catalogue of fictitious fruit essences and fictitious fruit wines that were employed to kill the "fire" of raw grain whiskey, and give the desired bouquet to "silent" spirit, were found to bring blindness and death—the lesion being in one and all, nerve atrophy, commencing, as a rule, in the optic nerve. The question suggested itself to what constituent of Jamaica ginger and made prune and other innocuous fruit products these poisonous effects were due? The study was undertaken by Hynson, who analysed quite a number of these flavouring essences, which were used for giving aroma and age-flavour to the liquor of the toper and producing the non-alcoholic beverage of the teetotaler alike, and in all he found methylated spirit—although they were described on the label as being prepared from ethylic spirit. It is but a few weeks ago since we drew attention to the poisonous properties of methylated alcohol in commenting on an inquest of a commercial traveller who died from sipping a preparation made on this spirit. Varnish drinkers suffer from optic atrophy, and not unfrequently from paralysis. From the literature of the subject it appears that the inhalation of the fumes of the alcoholic produce cause deleterious effects. Dr. Schweinetz (*Memphis M. Monthly*) reports a case of amaurosis occurring in a varnisher who used a polish made on methylated spirit. As it is, the law prohibits the use of methylated spirits in the preparation of foods, or any substances, medicines, or otherwise intended for internal use. We believe that when attention is drawn to the subject that the evil will be suppressed, and as in the case of arsenic in beer the public health officers will give the beverages of the people the benefit of their attention.

## Notes on Current Topics.

### Another Suicide at a Kent County Asylum.

IN our issue of August 28th it was our duty to comment somewhat severely upon the circumstances under which an inmate of Barming Heath Asylum committed suicide. At the ensuing inquest it was stated in evidence that there was only one attendant in charge of a ward of forty-four patients, several of them of a suicidal tendency. At the time we expressed the opinion that the Lunacy Commissioners might safely be left to deal with the matter, assuming the state of affairs to have been that disclosed at the inquiry. It is hardly creditable to the management of the asylum that within a few weeks another case of suicide should be reported. The deceased was a young woman who suffered from "restless melancholia"; she was allowed to go from her ward to a dormitory for some needlework, and as she did not return a search was made and her body was found hanging from a cistern pipe by means of a strip of calico. It was stated that the deceased had been away from the ward for twenty minutes before a search was made, and that the attendant in charge had been discharged for neglect of duty. It is to be hoped that in fairness to the latter a full statement was made before the coroner as to the number of patients under individual control, and all other details of the attendant's duty. The position of the authorities of the Barming Asylum is rendered unenviable from the recurrence of such disasters, and it is to be hoped that the Lunacy Commissioners will promptly investigate the whole administration of this large institution.

### A Mysterious Enteric Fever Epidemic.

AN outbreak of enteric fever is reported from Coventry. In a supplementary report from the medical officer of health it is stated that during the past two weeks thirty fresh cases of enteric fever have been noted, as against thirty-three in the previous fortnight. The cause of the outbreak appears not to have been yet definitely traced, although suspicion has been attached to a pump situated in a court opening on to a street in the neighbourhood of which there have been fifty-five cases notified during August and the first fortnight of September. The water of that particular well enjoys a considerable reputation with regard to its coolness and superior taste, and it has been certified by Dr. Bostock Hill to be remarkably pure for a surface well water, and to show no trace of sewage pollution. The medical officer remarks that applying the test of mere numbers the milk might be more strongly suspected than the water, for while forty-four out of the fifty-five patients had partaken of the water, no less than forty-six had obtained their milk from a common source. Dr. Snell makes the extraordinary comment that the present outbreak was attracting undue attention, inasmuch as cases were never absent from the town, and should always receive attention. That

attitude is not a little curious, and the townfolk are hardly likely to endorse that part of it which concerns the "undue" attention, especially while the origin of the epidemic remains undiscovered. Now and then the source of enteric fever baffles the most skilled investigation. Only last year one ingenious investigator advanced a theory of origin in fried fish shops, but the requisite proof has not yet been forthcoming. Speculation and enterprise, however, are more desirable qualities than fatalism in the equipment of the modern Medical Officer of Health.

### Pharmacy and Medicine.

IN the introductory address delivered by Dr. Luff before the Pharmaceutical Society, an abstract of which we publish elsewhere, the lecturer emphasises a fact to which we have often alluded, namely, the extraordinary stimulus to self-medication which the introduction of "compressed prescriptions" has given rise. To medical men active principles in this form prove extremely convenient, but the ready facility with which powerful drugs in this form are obtainable by the public constitutes a real danger. Then, too, the practice of prescribing exactly on the lines laid down by manufacturing chemists is derogatory to the science of therapeutics, and testifies to a regrettable want of original thought on the part of those who avail themselves thereof. Even more open to objection is the tendency to prescribe proprietary articles, the composition whereof is given, if at all, only in the vaguest way. Dr. Luff was sure of a sympathetic audience in touching on these practices, for they are as prejudicial to scientific pharmacy as they are to therapeutics. His explanation is that the art of dispensing is declining in consequence, he believes, probably with reason, of the altogether inadequate attention which is given to this important branch of study in medical schools. It is a significant fact that we called attention to this lapsus in medical training in our last number, thus forestalling the lecturer, who is but voicing a feeling very generally expressed in medical and pharmaceutical circles. Let us beware lest, by our neglect of this, the practical aspect of therapeutics, we bring medicinal treatment into contempt and degrade the pharmacist into a mere vendor of ready-made preparations.

### The Consumption of Salt.

ALTHOUGH in treatises on dietetics salt figures as a condiment, it is universally recognised to be something more; indeed, it is an indispensable element of the food of man and animals. A well-known authority asserts that whenever the annual consumption of salt falls below twenty pounds per head of the population the public health is likely to suffer. In regions of the earth where salt is a scarce article it is regarded as a substance of great value, and salt starvation is, in its way, as distressing as thirst or hunger, although it is manifested in less obvious fashion. This fact long since suggested to impetuous governments an easy means of raising

money, viz., by imposing a duty on this indispensable article of food. In Italy, even at the present day, it is a penal offence to evaporate a bucket of sea water for the purpose of obtaining salt, but nowhere is this iniquitous tax applied on so large a scale as in India, where it forms the principal source of revenue. The deprivation of salt does not produce a definite disease, but reduces the vitality of the organism as a whole, so that the victim of administrative measures which restrict the consumption of salt more readily fall victims to prevailing epidemics, as well as to endemic maladies. How far this factor is at the root of the proneness of our Indian subjects to plague and kindred diseases is a point which might well engage the attention of physiologists and pathologists. A free breakfast table, which was long the device of a once popular school of politicians, is of vastly less importance in respect of the public health than free salt. The matter is one which will sooner or later be forced upon the attention of the Indian Government. This nation stands voluntarily *in loco parentis* to the natives of our Indian territories, and common humanity suggests a careful study of the question in its bearings on the health of those of whose well-being we have made ourselves the custodians.

#### An Old Treatment for Scarlatina Revived.

READERS of De Foe's little known "Roxana" may remember the description of the spare bedroom which was draped in red cloth and was kept for such cases of sickness as might arise. The old four-posters, with their heavy drapery of crimson cloth, were the sole survivors of the custom of the red-draped bedroom in modern days. The origin of the practice had been forgotten, but the custom remained of surrounding the sick man with red drapery; it was handed down for centuries, and was recommended in the *Rosa Anglica* (1305-1307) by John of Gaddesden, who probably borrowed it from Gilbert's "Laurea," written when medicine was at its lowest ebb in England. Physicians then seemed to gain respect neither for their skill nor conduct. Piers Plowman writes: "Murtherers are many leaches," and again "Lord, them amend." As our readers are aware the practice has been in some degree revived, especially in cases of small-pox and scarlatina, and Don Julian Garcia Suetto (*El Siglo Medico*) reports a case demonstrating the successful use of red rays in the latter disease. The patient, a child two years old, had a severe attack, and on the fourth day of the illness the windows of the bedroom were covered with red cloth. At this time the temperature had reached 104.5°, the tongue, mouth, throat, and tonsils all indicated a fever of great severity. The only medication given was the sixth of a grain of the sulphate of quinine every two hours. Three days afterwards the child was convalescent, the temperature normal, and the little patient almost in her ordinary health. No mention is made of the desquamation of the skin or of the condition of the alimentary canal on this date. The case is interesting both as a revival of a treatment

so many centuries ago discontinued, and from the wonderfully good results that treatment gave. We think it is worth trying; it is easily and inexpensively carried out, and in no way precludes the ordinary treatment.

#### Whooping-Cough.

EVERY phase of medical thought seems to bring its impress on the pathology and ætiology of whooping-cough. The story of changing views is seen in the multitude of remedies that as a cloud of witnesses tell how unsuccessful our search for the source of the disease has been. Still the search continues, and M.M. Jochmann and Krause (*Zeitsch. fur Hyg.*) consider that from an examination of the expectoration of eighteen patients suffering from the disease they have found a specific bacillus. They describe the bacillus as very small, remarkably thick in proportion to its length, discoloured by Gram's fluid. It was discovered some time ago by Eppendorf and physically its appearance resembles that described by Czaplowski; but it is more readily cultivated. Besides its morphological characters, it is known by its regaining colour after being decolourised by the Gram fluid. If this latest of theories is accepted we may expect to find the disused vapourisers and inhalers once more called into activity, and the old time remedies of creosote, phenol, coal-tar, and so forth again actively employed. The bacterial theory is, however, quite as good as any other, and we make no objection, though we cannot see how it explains the onset of a paroxysm of coughing on the swallowing of some solid food—a phenomenon so familiar to the long-suffering hard-worked general practitioner.

#### Wanted--a Test for Drunkenness.

THE conflict of evidence that goes on every day in the police courts of the United Kingdom as to the soberness or otherwise of a defendant emphasises the need of a trustworthy test for drunkenness. The error of hasty inference from such signs as the smell of drink, staggering, vomiting, heavy breathing, thick speech, and unconsciousness has been written in many a police cell tragedy. Indeed, the most striking of journalistic headings, "Drunk or Dying," is never absent from the newspapers for any great length of time. Nor is medical advice itself always infallible. The fact of the matter is that it is often a most difficult task to decide whether a certain individual is or is not under the influence of alcohol to such an extent as to render him incapable of being at large with safety to himself and to other people. The standard of the police inspector, of the intelligent constable, of the surgeon, and of the prisoner, are all personal and extremely variable factors. The pronouncing of certain difficult words or combinations of words of the "truly rural" type constitutes a fair test, especially when supplemented by the handwriting. An individual, however, may be unable either to read and write, or to speak in any but his own dialect, or he may be incapacitated by disease from exercising either accomplishment.

The so-called "heel and toe" test is clearly fallacious, as many sober persons would find it a difficult or impossible physical feat to put one foot before the other in the requisite straight line. The fact is that to diagnose alcoholic poisoning demands in not a few instances a most thorough and careful skilled examination of a number of circumstances, including history, nervous system, and state of the bodily and intellectual functions. For a police inspector or surgeon to endeavour to settle the question off-hand on the strength of a single sign or symptom or arbitrary "test" is to court tragedy and disaster.

#### Welshmen on the Hill Top.

It is a well recognised fact that Welshmen are addicted to the tops of mountains for the celebration of various national rites and ceremonials. This trait has lately shown itself in an unexpected quarter, namely, among the medical fraternity of the gallant little Principality. Last week a meeting of the North Wales Branch of the British Medical Association was held on the top of Snowdon. Members were not called upon to climb wearily to the summit of the mountain, as in days of yore, but were carried up thither comfortably and quickly in the five-mile tramway that now stretches from base to peak. The presidential address was delivered by Dr. R. Parry, ex-Mayor of Carnarvon. Among other speakers, Dr. Mills Roberts, from the Welsh Hospital in the Transvaal, related his military experiences. There is a pleasant suggestion of poetry and romance about this meeting place that one often looks for in vain in the halls of modern medicine. The completeness of the picture would be perhaps a little more nearly approached were the Executive Committee to appear in the crown of gold and other appropriate ancient garb, and the members to attend clad in whatever dress was affected by the Cymri of the past in their sacred excursions to the hill tops. Loftiness of aim is a thing to be cultivated by all earnest upholders of the dignity of the profession, even when it concerns a local branch of the British Medical Association. The organisers of the Snowdon meeting may be heartily congratulated on the freshness and originality of their conception.

#### Medicine as a Profession.

THERE is no doubt that owing to various circumstances, not the least whereof is the strengthening of the curriculum, the practice of medicine offers greater advantages than it did ten years ago. As Professor Risien Russell points out in his introductory address, an abstract of which we publish elsewhere, the proportion of medical men admitted to registration has fallen, while the population has, of course, increased. The result is that newly-qualified men are able to pick and choose, as they have shown by their voluntary abstention from posts in the Services, in spite of sundry ameliorations which have been wrung from a reluctant Government. The lecturer touched upon one point which is likely to

force itself upon our attention more and more as years go by, namely, that no material improvement in the status of the profession can take place so long as the bulk of men dispense their own medicines, and thus, in the eyes of the public, degrade themselves into mere vendors of drugs. So long as this practice obtains the public will distinguish with difficulty between the duly qualified practitioner and the retail chemist who is so frequently addressed as "doctor" by his customers.

#### The Art of Cooking.

THOSE of our readers who are old enough to remember the late Professor Hargreaves' lectures will recall the importance he attached to the value of good cooking in the treatment of disease. He insisted that cooking for the sick was a fine art. This idea seems to have taken root in Germany, for we find that a course of lectures on cooking for the sick has been commenced this year in the Medical School. The lecturer, Mademoiselle Hedwige Heyl, has a largely-attended class. Her pupils include not only Germans, but French, Russian, and Italian students. The lectures and demonstrations are of great interest to nurses, superintendents, mothers, and particularly so to young mothers. Mademoiselle Hedwige Heyl does not confine her demonstrations to the preparation of foods alone, she shows how the majority of medicinal remedies may be administered, even when unpalatable, in a pleasant manner in made dishes, without the necessity of taking the unmasked drug in pill or potion. A regular formulary for such cooked medicaments is published by her, and has become so popular that it promises to supersede to some extent our familiar nostrums.

#### The Scientific Investigation of "Consumption Cures."

THERE is a general feeling among the public that methods of treatment for consumption which are not brought forward through the orthodox channels are systematically boycotted by the medical profession. The argument is one, moreover, which is put forward by irregular practitioners who lay claim to having discovered a "cure" for this too prevalent disease. It will be news to many of our readers that provision at the Brompton Hospital for Consumption for the investigation of remedies for consumption was made nearly half a century ago, and is still available. According to a letter from Dr. J. E. Pollock, which was published in a recent number of *The Times*, the medical officers of that institution are authorised by the committee to avail themselves of any novel method of treatment which offers a reasonable prospect of usefulness. The only condition is that the nature and preparation of the proposed remedy shall be made known to them in writing. The authorities even go the length of admitting the person proposing such remedy to the hospital to observe its effects. A very large number of remedies and methods of treatment have been

tested—and found wanting—in virtue of this permission; but it is a significant fact that no secret or other remedy has ever been submitted by outsiders on these conditions, not even the at present notorious *Lachnanthes*. Of course everything would turn upon what the medical officers considered “a reasonable prospect,” and this, it would seem, has not been put to the test for the simple reason that quacks and men of the Alabone type prefer to compile their own statistics, and carefully steer clear of any scientific control.

#### Wanted, a Sumptuary Edict.

AMONG the regulations bearing on the duties and conduct of a newly-appointed lady sanitary inspector in Southwark is one which stipulates that she “shall provide herself with a uniform to be approved by the Public Health and Sanitary Committee.” We cannot contemplate without amused apprehension the prospect of a special meeting of the committee being summoned for the purpose of deciding upon the details of this lady official's toilette. If there are any lady members on the Board they ought forthwith to be constituted a “jury of matrons” to investigate and report, the task being so obviously beyond the scope of the average councillor. As an alternative, the committee might request the permission of the Board to throw the design of the uniform open to public competition, offering a small prize to the author of the accepted pattern.

#### Methyl Blue and Methylene Blue.

THE unfortunate experience of a medical practitioner in prescribing methylene blue should once more warn the profession against trusting too implicitly to chemists taking the necessary care to avoid confusing methylene blue with methyl blue. In the case referred to the practitioner noticed that the characteristic blue colour did not make its appearance in the urine of a patient for whom he had prescribed methylene blue. A visit was accordingly paid to the druggist, and an examination was made of the supposed methylene blue, when it was discovered that methyl blue had been dispensed in error. The next time the practitioner prescribed methylene blue he saw the chemist who was to make up the prescription, and upon being assured that he knew the difference between methylene and methyl blue he did not consider it necessary to insist upon inspecting the bottle in which the drug was kept, but in this instance again the same mistake occurred and methyl blue was substituted. To avoid any further mistake of the kind, the physician arranged that the methylene blue for his patients should be dispensed from a stock of undoubted methylene blue put up in gelatine capsules; but a fresh assistant disturbed this plan by placing methyl blue in the capsules. The error seems peculiarly liable to be made, and in one instance the substitution was almost on a wholesale scale, for a chemist who had ordered a supply of methylene blue received instead a large quantity of methyl blue, and it was not until a number of unfor-

tunate patients had suffered distressing attacks of vomiting that enquiry elicited an explanation of the affair. Every possible care should be taken in prescribing the drug to avoid this untoward substitution, and it is well to remember that methylene blue can be distinguished from methyl blue by the fact that the meniscus on the surface of a solution of methylene blue has a green colour, while that of methyl blue is blue under all circumstances. Moreover, if sodium hydroxide be added, methyl blue becomes purplish red, but methylene blue turns to a deep violet colour. Another practical test is that methylene blue solution does not change colour on the addition of ammonia, which decolourises a solution of methyl blue.

#### Water in Butter.

THE presence of excess of water in milk has long been recognised by the public as a common offence. That form of adulteration is so palpably suggested by the pump and the water-tap that the average honest milkman who withstands its blandishments must be credited with unusual strength of mind. It is otherwise, however, with the more subtle form of adulteration which introduces an excess of moisture into the substance of butter. The milkman sells his added water at the price of milk and the butterman at the price of butter. The latter tradesman, therefore, gets a much bigger profit out of his fraudulent practice. For some time past a London firm, Messrs. Pearks, Gunston, and Tee, have engaged in extensive operations in the butter trade, and it has been shown that their butter in several cases has contained excess moisture. In Marylebone they have been convicted on eight summonses under the Sale of Foods and the Merchandise Acts and heavily fined. The excess of added water varied from four to nine per cent. beyond that usually allowed. The magistrate remarked he had seen an advertisement stating that a quarter of a million of people were eating the defendants' butter every morning at breakfast, and notwithstanding the water they liked it better than ever. It is clear that trading operations conducted on a large scale under such conditions must yield profits sufficiently large to pay for many fines.

#### Singers' Nodules.

NODULES the size of a pin's head have been noticed upon the vocal cords of singers, and are known by the name of “singers' nodules.” These are described by Dr. Chiari as consisting of hypertrophied epithelium and connective tissue, occasionally containing dilated blood-vessels but without any trace of glandular structure. Much confusion has arisen in regard to these nodules, chiefly from the want of a clear definition of what was meant by the term. Anything in the nature of a growth which has a pedicle should undoubtedly be excluded from the group, and any tumour larger than the size of a pin's head does not come under this head. Another distinctive feature of these nodules is their situation upon the free edge of the cord, at the junction of the middle with the anterior third, and it is laid down that this is the only position in which they grow.



### Chinese Laundries.

Nor long since an attempt was made to establish a Chinese laundry in London, and it was very pertinently remarked at the time that probably but few people in the metropolis were familiar with the method of washing employed by the Celestials. A Chinaman of St. Louis, who worked in one of the laundries, was recently discovered to be afflicted with leprosy. In the opinion of an expert he has been in a leprosy condition for nearly ten years, during the whole of which time his occupation has been that of a laundryman. When washing, the Chinese are said to sprinkle the articles of wearing apparel by forcibly ejecting water from the mouth. The inhabitants of St. Louis were terribly scared on learning that the breath of a leper, especially during the act of sneezing, has been found to abound in leprosy bacilli. The nasal secretion of the leprosy Chinaman was examined, and the presence of the specific bacillus demonstrated therein. The quarantine officials of St. Louis have erected a special building for the patient, and the incident has led to the demand that the Chinese should be subjected to a rigid inspection. Without wishing in any way to minimise the dangers incidental to leprosy, a certain amount of comfort may be drawn from the consideration that the great majority of dermatologists hold that leprosy is but slightly contagious. There is an instance on record where a handsome young lady of good family married a leper and lived with him eight years. Partly through jealousy on his part and partly through devotion on hers, they made every effort to have the disease in common, even going the length of making numerous attempts to inoculate the malady. The husband, however, ultimately succumbed to the disease, and the widow survived in perfect health. There is, of course, a mass of testimony to prove that leprosy may be communicated under exceptional circumstances, and it is generally admitted that a proclivity to the disease is inherited by the offspring, in which case exposure to infection may be followed by development.

### Reform of the Army Medical Service.

THE committee appointed to report on the steps to be taken to increase the efficiency and restore the popularity of the Army Medical Service have lost no time in formulating a series of recommendations which, it may be hoped, will go far to place that department of our army in a position to cope with the requirements of modern warfare and to secure a numerically sufficient staff. The recommendations may be grouped under four heads, viz., the creation of an Advisory Board, the position and duties of the Director-General, the appointment, pay, and promotion of the medical officers, and, lastly, the duties of certain officers. The Advisory Board will consist of the Director-General and his deputy, of two officers, one being an expert in sanitation, and the other in tropical diseases, of two civilian physicians and two civil surgeons. With these there will be a repre-

sentative of the War Office, and one appointed by the Secretary of State for India, the nursing department being represented by the matron-in-chief of the Queen's Imperial Military Nursing Service. This board will discharge many functions hitherto filled by the Director-General, and will report direct to the Secretary of State, who thus becomes virtually the head of the department, the Director-General being *ex officio* the president of the board. The scheme of examinations is modified in that the entrance examination will henceforth bear only on clinical and practical medicine and surgery. After a period of training at Aldershot, followed by an examination in military law and technical subjects, the candidate will be attached to a regiment for duty, attached to which there is a station hospital. Three years later the officer may, if he choose, retire from the service, or he may elect to continue therein or engage for seven years in the Reserve of Officers. Should he elect to continue in the Service he will be sent for six months to a civil hospital, when he will be called upon to undergo a further examination the result whereof will greatly influence his future career. The scheme comprises the establishment at an early date of a Medical Staff College in connection with a large military hospital in London, which will provide every facility for special branches of study. An increase of pay all round is contemplated. The neo-lieutenant will receive £323 10s., and the Director-General £2,000 per annum. The retired pay and gratuities are unaltered, except for the £25 a year in the Reserve and for additional gratuities of £1,000 and £2,500 for retirement after nine and eighteen years respectively. We shall return to this subject next week, when we shall discuss more in detail the mechanism by which these results are to be obtained.

### Drunkenness Among Women.

THERE is reason to suspect that women are becoming more prone to alcoholic drinking, and a lady temperance lecturer recently charged the medical profession with "aiding and abetting" the present deplorable state of things by prescribing alcohol indiscriminately. Let us consider how far such a charge can be substantiated. During the past two or three decades, it may be unhesitatingly asserted, members of the medical profession have acknowledged the duty incumbent upon them to exercise the greatest prudence in prescribing alcohol. It is now almost the rule to order it in measured doses, and is withdrawn when its purpose has been fulfilled. We know that alcohol, in the form of whisky or brandy, is too often a domestic remedy, a sort of universal panacea, though a very untrustworthy one in irresponsible or reckless hands. We know an instance in which a mother had for years given her daughter at her menstrual periods two or three glasses of whisky to relieve the suffering of the first day or two. Such a practice, repeated monthly over a considerable time, was surely calculated to create an appetite for strong drink. When other

remedies which are quite safe can be given to relieve menstrual pain, and that often very speedily, surely a grave responsibility rests with those who thoughtlessly but regularly dose their children with whisky at such times. The mention of this case should cause medical men to be on the alert for other cases of a similar kind, so as to put a stop at once to a most pernicious practice. We know two large cities, at least, in which drinking among women has spread to an alarming extent. There can be no doubt whatever that many women avail themselves of the ready and dangerous facilities offered by the licensed grocer for obtaining their accustomed stimulant, at least in the initial stage of their drinking. We believe we express the wish of the medical profession generally that grocers' licences should be withdrawn at the very earliest possible date. If temperance reformers will energetically exert themselves in that direction they will have, we are sure, the most hearty co-operation of the medical profession in removing from our midst what has long been recognised to be a serious menace to the sobriety and virtue of our female population. We think we have said enough to dispose of the allegation brought against the profession of carelessly prescribing strong drink. Therapeutically, alcohol has its proper place, and we are convinced that the medical men of to-day prescribe it with as strong a sense of responsibility as in respect of any other therapeutical agent. We are glad to find among the ranks of temperance reformers many influential and leading members of the medical profession who really do "practise what they preach."

#### The Medical Aspects of President McKinley's Death.

THE evidence given at the trial of the murderer of the late President of the United States finally disposes of the sensational statements emanating from certain too enterprising American journals as to the "mysterious concatenation of circumstances" which characterised the treatment, and the reported disagreement between the surgeons in attendance. Viewed in the light of the statements made under oath at the trial of the murderer, the course was just what experienced surgeons would have expected. Recovery would have been a brilliant triumph for surgery, but failure to prolong life involves no discredit upon either the operation or the surgeon who performed it. The optimistic tone of the bulletins was unavoidable under the circumstances, indeed, they were only optimistic to those who were unable to read between the lines. In professional circles it was felt from the first that in view of the late President's age and sedentary habits a successful outcome was exceedingly unlikely.

#### PERSONAL.

MAJOR CROOK CAWLEY, R.A.M.C., Surgeon to the Coldstream Guards, has been ordered to take out the draft of 100 men of the Royal Army Medical Corps embarking next week for South Africa.

WE are glad to be able to state that Dr. Peckett, the Medical Officer of Health for Leyton, has now almost entirely recovered from the effects of the serious trap accident he met with on Sunday, August 18th.

MR. E. RICE MORGAN, M.R.C.S., L.S.A., of Morriston, Swansea, has been presented with an illuminated testimonial and a diamond ring by his patients and friends on his return from a voyage round the world to recruit his health.

LORD BRASSEY has consented to preside at a public meeting to be held at the United Service Institution on Wednesday, October 16th, in connection with the opening of the third winter session of the London School of Tropical Medicine.

DR. MITCHELL BRUCE will deliver the first Hunterian Lecture of the session before the Hunterian Society, at the London Institution, Finsbury, on Wednesday next, October 9th, the subject chosen being "Chest Complications in Abdominal Disease."

MAJOR-GENERAL SIR IAN HAMILTON, one of the most popular of our South African soldiers, will distribute the prizes to the successful students of St. Thomas's Hospital, London, this afternoon (Wednesday) at 3 p.m. A large gathering is expected.

SIR THOS. N. FITZGERALD, F.R.C.S.I., Senior Surgeon to the Melbourne Hospital, who served in South Africa during the early stages of the war, and whose services were rewarded with a K.C.B., is on his way to this country on six months' leave of absence.

THE following officers of the Royal Army Medical Corps have been placed under orders to leave Aldershot:—Lieutenants Wells, Faulkner, and Mason, for South Africa; Lieutenant Brunskill, for West Africa; Lieutenant Bostock, for Malta; and Surgeon-Lieutenant Beggs, for Belfast.

A LARGE gathering of past and present students of Westminster Hospital is expected at the annual dinner on Friday evening, under the presidency of Mr. Chas. Stonham, F.R.C.S. About 100 names as stewards have been already given to the hon. secs.; these will be found on reference to our advertising columns.

DR. ALFRED DOUGLAS AIKMAN, of Hull, has been selected from over three hundred medical practitioners to proceed to the Gold Coast of West Africa at the instance of the Associated Boards of the Gold Mining Companies, for the purpose of making an independent investigation into the aetiology of malaria.

DR. E. SYMES THOMPSON, Gresham Professor of Medicine, will deliver a course of lectures on "The Tuberculosis Congress," in Gresham College, Basinghall Street, London, on October 8th, 9th, 10th, and 11th, at six o'clock each evening. The lectures will be illustrated by diagrams, and are free to the public.

WE announced last week that Dr. Yellowless was about to resign his position as medical superintendent

of the Glasgow Asylum, at Gartnavel. He unfortunately sustained an injury to one of his eyes by a carriage accident a few months ago, which necessitated him taking rest for some time. The directors wished him to take a holiday for six months, but he has preferred to resign after twenty-seven years' faithful service, which is very fully appreciated by the board of directors. His tenure of office has been a peculiarly successful one, and his retirement is deeply deplored by directors, patients, and Asylum staff alike, by all of whom he is held in the highest esteem. The directors have just appointed him honorary consulting physician, thereby retaining his connection with the Asylum. His successor will receive a salary of £1,000, with free house, &c.

ROYAL ARMY MEDICAL CORPS.

To be Companions of the Order of the Bath.—Col. J. A. Clery, M.B., Lieut.-Col. A. P. O'Connor, F.R.C.S.I., Major (now Lieut.-Col.) T. R. Lucas, M.B., Major (now Lieut.-Col.) F. A. B. Daly, M.B., F.R.C.S.I.

To be Companions of the Order of St. Michael and St. George.—Cols. W. H. McNamara, M.D., F.R.C.S.I., C.B., and Col. E. Exham, Lieut.-Col. J. C. Dorman, M.B., Major (now Lieut.-Col.) H. J. Peard, Majors S. F. Loughheed, M.D., A. F. Russel, M.B., S. Westcott, R. Kirkpatrick, M.D., R. J. S. Simpson, M.B., T. W. O'H. Hamilton, M.B., S. F. Freyer, M.D., N. C. Ferguson, M.B., H. C. Thurston, and O. R. A. Julian.

To be Companions of the Distinguished Service Order.—Majors R. J. Geddes, M.B., and A. A. Sutton, Capt. F. Smith, H. J. Parry, M.B., F. J. W. Porter, H. J. M. Buist, M.B., and E. M. Pilcher, M.B., Lieut (now Capt.) C. J. O'Gorman, Lieut. (now Capt.) R. S. H. Fuhr, Lieuts. G. G. Delap, H. Ensor, M.B., and L. N. Lloyd.

To be Majors.—Capt. S. G. Moores and J. H. E. Austin.

To have the honorary rank of Major.—Qrmer. and Hon. Capt. T. F. Kennedy (now retired pay).

To have the honorary rank of Captain.—Qrmer. and Hon. Lieut. S. Duffield (since deceased), Qrmer. and Hon. Lieut. F. Crookes.

To have increased rate of pay under Article 232, Royal Warrant for Pay, &c.—Qrmer. and Hon. Capt. E. Thowless, Qrmer. and Hon. Lieut. (now Hon. Capt.) J. Hirst, Qmrs. and Hon. Lieuts. A. Bruce, J. C. B. Whitehorn, F. Bruce, T. Exton, T. J. Jacomb, and A. H. H. Niblett.

To have the Distinguished Conduct Medal.—Fst. Cl. Staff-Serjt.-Major J. de S. Stewart, Serjt.-Majors R. Watson, A. R. Titchener, D. Roberts, and F. B. Bowyer; Fst. Cl. Staff-Serjts. F. H. Dolman, J. R. Gibbons, and C. W. Measures, Snd. Cl. Staff-Serjt. N. Cornell, T. Johnstone, H. Lettemore, F. S. Marsland, J. Hampton, and R. Burrows; Staff-Serjt. C. H. Cooper; Serjts. T. H. V. Coad, J. Leonard, J. Bright, and E. I. Cadogan; Lance-Serjts. T. Davey, and F. G. Bright; Corpl. W. H. Servey; Ptes. A. Nunn, J. Harvey, M. T. Sparkes, H. Burford, E. N. Macgregor, (Hospital Orderly), D. Stuart, attached, and (Hospital Orderly), F. W. Woodier, attached.

Correspondence.

[We do not hold ourselves responsible for the opinions of our correspondents.]

"LACHNANTHES TINCTORIA."

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In my last letter I was rash enough to make the statement "that no solid scientific data would be forthcoming to establish the claims put forth for the 'lachnanthes treatment,' and that the only evidence adducible would consist in 'testimonials from grateful patients' of exactly the same value as those which bear witness to the power of Holloway's pills and oint-

ment to root out the totally distinct causes of several score of totally diverse diseases." In this it is evident I was wrong. I ought to have added that the evidence of grateful patients would certainly be supported by the testimony of some such well-known scientists and members of the profession as Mr. H. J. Buck, L.B.C.P.Ed., of Clapton Common, whose communication follows mine in your current number. No one would be impertinent enough to ask Mr. Buck for an accurate clinical record including a verified diagnosis of a single one of the many cases "given up as absolutely hopeless," of which he has had experience during the last ten years, and which, under "Mr. Alabone's treatment have recovered and remained in good health;" everybody will be willing to accept the unsupported *ipse dixit* of so great an authority; and there is nothing more to be said here. But Mr. Buck's letter affords some further valuable information. It informs us that lachnanthes "is only one of the drugs Mr. Alabone recommends," and that the administration of these drugs is "combined with the open-air treatment." We are not told whether Mr. Alabone was the inventor of the open-air treatment which has been recommended by Mr. Buck "during the past ten years"; and whether a general boycott by the profession throughout the civilised world, led in this country by the General Medical Council (as suggested in *The Times* by Colonel Le Poer Trench), has prevented suffering humanity from being made aware of this as well as of the lachnanthes treatment until quite recent times. At any rate, Mr. Buck's letter has put quite a different complexion on the whole matter. Everyone now can perceive the wisdom of Colonel Le Poer Trench's last suggestion, namely, that an Alabone institution shall be at once opened wheresoever medical candidates can "qualify" in the special treatment before being admitted to examination. When this is done and Mr. Alabone is appointed president of a newly constituted General Medical Council, no doubt the boycott against his methods which has been practised not only at home but in Germany, France, and the United States will be removed; an ill-used, even martyred man will be reinstated in the eminent position he deserves; and the cases of constructive murder described by Colonel Le Poer Trench will no longer disgrace the profession; for no longer will wretched patients, merely to gratify professional spite, or at the dictates of a sordid trades-union organisation, be allowed to perish miserably whilst in reach of the salvation offered in Mr. Alabone's neglected treatment.

I am, Sir, yours truly,

September 27th, 1901.

UBIQUE.

"LACHNANTHES TINCTORIA."

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Dr. Buck states in his letter in your last issue that lachnanthes is only one of the drugs which Mr. Alabone recommends in his treatment. Does Dr. Buck, however, deny that Mr. Alabone pins his faith entirely upon lachnanthes, asserting as he does, in his book on "Consumption," in reference to the other drugs, "if used by themselves cases do not recover, which is conclusive evidence that they exercise no curative effect" (page 170). With regard also to the question of inhalants, Mr. Alabone also states in the same book (page 170), "but in all cases an ethereal tincture of lachnanthes should enter largely into the composition." It is quite clear that the only difference between the treatment of consumption by Mr. Alabone and that of registered practitioners is the use of lachnanthes, a drug which was described by Mr. Morton, who "assisted" Mr. Alabone for more than sixteen years in his "practice," according to the evidence sworn by him in court (*Alabone v. Morton—Times Law Reports, June 19th, 1893*), as "worthless as a medicine, in fact the whole compound was in his opinion a bogus." I am not aware that any action for perjury has ever followed, and therefore this evidence must stand as reported.

I hope that Colonel Trench will find some other way of depleting his balance at his bank more in accordance with the true spirit of charity, and more helpful to those

who may suffer from the disease which, in spite of many advertised cures, still baffles the world.

I enclose my card, but prefer to sign myself,  
DAMOCLES.

#### THE BIOLOGICAL TEST.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—If Mr. Berdoe seriously reconsiders his position he may discover that he is arguing upside down, and in this respect he reminds one of an amusing story of a certain barrister who upon one occasion was haranguing and gesticulating before a jury in the fashion so characteristic of the cloth, and what he said was admirable, but somehow he got mixed up with his other briefs, when all at once it occurred to him that he was arguing for the opposite side, but with commendable promptitude and wit he turned the tables by explaining to the jury that what he had hitherto been talking about was precisely what the opposing counsel would say. In the same sense Mr. Berdoe is admirable in what he says, but in my opinion, judging from his first letter, to say nothing of his last, that he is in reality arguing in favour of the vivisectionists, and if he only reads less and thinks more, or in other words uses his own brains in lieu of other peoples, he, like the barrister, will probably find out his mistake.

With regard to Mr. Berdoe's criticisms to my letter they appear to me altogether frivolous; for example, he says, "The biological test in my relative's case had a positive, not a negative result." If Mr. Berdoe will kindly refer to my letter he will discover that I was speaking of inoculation in the lower animals when no disease is established, whereas, regarding Mr. Berdoe's niece tuberculosis was incurred, hence, as he truly says, "the evidence was positive." As to his objection about the beef-tea on the score that experiments on animal and man are not identical, although, of course, in many cases this is so; nevertheless, on the other hand, I submit some are fairly conclusive; for example, I presume a corrosive or irritant poison if tested on an animal would produce similar results as in man, whereas a narcotic might have quite an opposite effect. The only possible exception that could be taken in this beef-tea experiment, as I conceive, consists in this, viz., that certain allowances might have to be made as to constitutional distinctions between the two animals, thus the one deprived of all food might be a much more vigorous or robust animal than the other, which in some measure would contribute to the incident of its living longer. Further, I never for one moment stated that beef-tea was valueless as food for invalids, because, as is so well recognised, it would play its part as a nitrogenous element in making up a complete dietary for a sick person.

I am, Sir, yours truly,

CLEMENT H. SEES.

Queen's Road, Peckham, September 25th, 1901.

#### THE ELECTION OF DIRECT REPRESENTATIVES.

We are requested by Dr. Glover to publish the following:—

FELLOW PRACTITIONERS OF ENGLAND AND WALES,—In offering myself again for re-election as one of your direct representatives in the Medical Council I have two duties to discharge. First, to thank you, as I do most heartily, for a long period of confidence and support on your part, shown at three elections. Secondly, to explain the principles on which I have endeavoured to act as your representative in the General Council of Medical Education and Registration, and to which I shall adhere in the event of your again electing me.

The recent address which I delivered at Cheltenham and my action for years in the Council make it unnecessary for me to do more than very briefly indicate my views.

First, I have endeavoured to the best of my ability, in respect of medical education, to make it, above all things, clinical and practical, basing it on as high a standard of preliminary education as the state of our general education will permit.

Secondly, I have laboured to maintain the purity of the *Register*, and, while not lightly using the disciplinary power of the Council, have not hesitated to apply it in the case of those who knowingly and persistently violate those traditions of the profession which are necessary for its honour and for the protection of the public.

Thirdly, in regard to Legislation to regulate the work of midwives I have kept in view the following objects:—(a) Stopping the practice of "Sarah Gamps" as we stop the sale of poisons. (b) Limiting the practice of midwives to simple cases and placing them under strict compulsion to call for the assistance of regular medical practitioners on the occurrence of any irregularity or abnormality in mother or child. (c) Providing, in respect of the training and certification of the work of midwives, a Board to do, with the sanction of law, what is now done without legal authority by the Obstetrical Society of London, and by other more or less irregular bodies. (d) As midwives are not medical practitioners, and can only safely work under the supervision of such practitioners, I can only support legislation for recognising them on condition that it secures the above objects, by making the Midwives' Board to consist chiefly of medical men and subjecting its regulations to the approval of the General Medical Council.

Fourthly, I have consistently supported motions for an increase in the number of direct representatives in the Council, and I should support any reasonable proposals for reducing the size of the Council.

Fifthly, the Medical Council consists predominantly of the representatives of twenty or more qualifying bodies, these bodies having their own functions and responsibilities. It is very creditable to the Council and the bodies that so little friction has hitherto arisen between them and it. At present the best friends of medical education see, with concern and regret, a sharp difference between the Royal Colleges of England and the Council. I shall only say here that while ready to support the just claims of the Council to the loyal support of the individual bodies, I am in favour of avoiding any course which necessitates a reference to the Privy Council—which by law has the last word in any dispute between the Medical Council and the individual examining bodies—believing it to be in the interest of the Council and of the profession to settle differences without such reference.

Sixthly, I am strongly in favour of the formation of a Conciliation Board to remove friction in the working of Friendly Societies; to improve the position of the medical officers; and gradually to raise the conception of the value of medical service to the working classes. As acting chairman of a committee on these subjects I have been much impressed with the disposition of the leaders of the Friendly Societies to meet the just complaints of the medical profession; and I may add that the same impression has been made on my colleagues in the Medical Council and on the Committee of the Council of the British Medical Association. It will be a misfortune if the tendency in some quarters to disparage this movement should receive any sanction at the coming election of direct representatives.

Seventhly, the finances of the Council require the considerations of its members—the expenditure of late years having largely exceeded the income. Serious proposals have been made for raising a huge income for the Council by a yearly registration fee. I am strongly opposed to such a suggestion, and believe it to be unnecessary. The difficulty, in my judgment, is to be met rather by reducing the expenditure of the Council in obvious ways than by exacting what would be an annual tax from the profession. Medical politics may seem unimportant to the majority of practitioners—the large abstention of voters in past elections of direct representatives, amounting to two-thirds or more of the profession—give some colour to that impression. But medical politics deeply affect the welfare and reputation of the profession, and are entitled to the consideration of all who are in any way responsible for the composition of the Medical Council.

Such are the views on which I have acted as the direct representative of the practitioners of England and

Wales in the Medical Council. Though conscious of many error and defects, I appeal, with some confidence, to the broad and generous judgment of the profession, and remain, your obedient servant,

JAMES GREY GLOVER, M.D.

25, Highbury Place, N.

### Special Article.

#### TRICHLORACETIC ACID.—A NEGLECTED REMEDY.

By GEORGE FOY, F.R.C.S.I.,

Surgeon to Whitworth Hospital.

EARLY in the century, when Berzelius considered organic chemistry to be the chemistry of the organic radicles, Dumas rather startled the chemical world by his promulgation of his theory of metalepsy. Based on his experiments on oil of turpentine in 1834, by which he found that he could substitute an atom of chlorine for each atom of hydrogen, he practically overthrew the theories which had already been adopted by Liebig and Berzelius, and generally accepted.

The close similarity between the names metalepsy and metalepsis, the rhetorical figure led to the word "substitution" being adopted by Dumas.

The substitution of atom for atom leaving a body that resembles the original body was the next theory of these products, and was due to Laurent, and not long afterwards Dumas discovered trichloroacetic acid, an instance in which the substitution product exhibits a close analogy with the original substance.

At first the acid was prepared by passing gaseous chlorine into a vessel containing a small quantity of acetic acid, whilst the mixture was exposed to sunlight; afterwards it was produced by acting on chloral hydrate with nitric acid in the presence of sunlight.

It occurs in colourless deliquescent crystals, which are readily soluble in water and rectified spirits.

For years the acid was looked upon as a chemical curiosity, the product that converted Dumas to the new theory.

The well-known preservative properties of acetic acid caused chemists to experiment with trichloroacetic acid, which they found to be a powerful antiseptic. These properties, however, excited no interest until Filipovitch (Vratch) in 1883, when using the acid as a test for albumen in urine, observed that urine treated in this way did not undergo any decomposition, even after standing for days. He now commenced a series of experiments to test its preservative action on beef tea, hay infusion, and other readily decomposable bodies, and discovered that a half per centum of the acid protects fluid from the development of fission-fungi, though it permits the growth of mould-fungi. Increased to the strength of two per centum, the solution arrested every sign of organic life for some months. In his urine-testing, Filipovitch made the important discovery that the acid does not precipitate peptones, and quite recently Combemale and Desoill (*Arch. prov. de Med.*), in examining the urine of eclamptic patients, found that in many samples the fluid contained albumen soluble in acetic acid, and they look on trichloroacetic acid as the only trustworthy test in such cases.

After its antiseptic properties had come to be well-recognised, it came to be prescribed in dyspeptic troubles, especially those accompanied by fermentation, or decomposition of food in the stomach, or the growth of sarcina.

In all these classes of internal diseases it came to be displaced by the salicylates and boric acid. A change brought about more by the lack of familiarity with chemical agents by prescribers generally than by the greater superiority of the more common drugs.

Its non-toxic properties recommended it to Russian surgeons as a dressing for wounds, and in 1889 Von Stein, of Moscow, published (*Med. Monat. f. Orth.*) his paper recommending the acid as an ideal cauterant. Applied to putrefactive surfaces it stops the decomposition, destroys the smell, does away with febrile con-

sequences, and promotes rapid healing. In acute coryza a weak solution brings prompt relief.

The acid has the drawback of being a painful caustic, hence in sensitive patients the drug should be used in association with an anæsthetic, such as cocaine. Ehrman (*Ueber Ausd. und Wirk. des Ac. Trich.*) claims for it that it is superior to chromic acid in that its action remains localised and is more persistent. A year later he writes (*Weiner Med. Blätter*) giving directions for its use. He applies the deliquescent crystals over the part which it is desired to cauterise. The tissues are whitened by the acid, an eschar forms, which usually drops off in eight or ten days, leaving a clean, healthy surface underneath. In this report he confirms all that O. F. Brown (*Am. Rhin. Assn.*) in 1888 had said in its favour. Sedziak, in 1890 (*Gaz. lek. Warsz.*) also recommends it as the best of cauteries for diseases of the nose and pharynx, and J. W. Gleitsman (*Med. Rev. N.Y.*) in 1891 published his experience with trichloroacetic acid in two hundred cases of affections of the throat and nose, strongly recommending it. He applies the acid with an aluminium rod, so fashioned that a cup-shaped depression exists at one end of it; this depression he fills with fine crystals, and applies directly to the affected part. To dull the pain he uses a solution of cocaine.

It has been found equally useful in the treatment of syphilitic and ordinary venereal ulcers.

As an application for verruca it is said to be painless and certain, the wart withering and quickly falling off.

Cozzoline (*Ther. Gaz.*, '94) thinks it is superior to either chromic acid or preparations of iron as a hæmstatic in epistaxia. He applies a pledget of lint or cotton wool wetted with a weak solution to the bleeding point and claims that it produces but slight reaction and gives prompt cicatrisation.

North (*Med. Rev., N.Y.*), 1897, advocates its use in the treatment of ozæna. He recommends its use after the crusts have all been removed, and there is no tendency for them to reform. He then applies a solution varying from one to five per centum.

As an application to ulcers, particularly indolent and phagedenic ulcers on the lips or cervix of the womb the acid produces much better results than the ordinary remedies. It promotes healthy granulation and leaves a small firm cicatrix. For sloughing ulcers about the vaginal orifice it is a sharp, rather painful, but prompt remedy.

### Literary Notes and Gossip.

"SPECIALISM" must have reached an acute phase when it has been found necessary to issue an "International Directory of Laryngologists and Otolologists" (London: Rebman, Limited). On the same principle, we presume, that almost every hospital must have its own little sheet, each special department in medicine must now possess not only its own journal, but its separate directory as well. The little directory before us, edited by Mr. Richard Lake, F.R.C.S., is excellently turned out, and forms quite an object-lesson in geography.

THE ancient "tallyman" appears to be making a courageous effort to re-assert his almost forgotten position. Complaints repeatedly reach us of the nuisance of book-hawkers, chiefly of American books, and American translations of German authors, who find their way into the waiting-rooms of busy practitioners and consume a lot of valuable time before they can be got rid of. Of course the profession have the matter entirely in their own hands. If at once discouraged the nuisance would of course cease, as it would not pay the publisher who sends them round unless orders for the books were secured.

ALTHOUGH little information concerning new books in medicine and surgery is forthcoming, new editions of standard works are more than usually numerous. Of these were announced in our *Students' Number* an eighth edition of Carter's "Elements of Practical Medicine," the fifteenth edition of "Gray's Anatomy," the fourth

edition of Halliburton's "Physiology," the fourth edition of Rose and Carless's "Manual of Surgery," the seventh edition of Allingham's "Diseases of the Rectum," the fourth edition of Osler's "Medicine," new editions of Muser's "Medical Diagnosis," Dr. J. Dixon Mann's "Forensic Medicine and Toxicology," Da Costa's "Medical Diagnosis," Dr. J. F. Payne's "General Pathology," and a third edition of Dr. Jellett's "Short Practice of Midwifery," of which a companion edition will shortly be issued entitled "A Short Practice of Midwifery for the Use of Nurses."

The last volume of the Glasgow Hospital Reports before us is, as usual, full of instructive material. It is impossible, in the short space at our disposal, to give any fair idea of the wealth of information this report contains. A year's work in one of the principal cities of the kingdom is told in its pages, and the editors have collected round them a staff of contributors who combine practical experience of disease with sound theoretical knowledge and facility of composition. The subjects of the twenty odd contributions to the number are happily chosen from the experience of the writers, and deal with subjects about which practitioners ever seek for information. Messrs. Maclehoose and Sons are the publishers.

MESSRS. P. S. KING AND SON, Westminster, have in the press a work by Dr. J. F. J. Sykes on "Public Health and Housing," being the Milroy Lectures delivered before the Royal College of Physicians in February and March last. The lectures have been carefully revised by the author, and many additions made which it has been considered would add to the completeness of the subject.

We have received the last number of the *Quarterly Journal of Inebriety*. The journal is edited and published in Connecticut, U.S.A., under the auspices of an association of American medical men. The object is so praiseworthy that we wish the association every success. In their efforts to promote sobriety enthusiasts adopt various methods, but there is none better, in our opinion, than an unvarnished statement of the moral ruin excess produces, and we have no objection to a plain moderate statement of the accepted theories of the action of alcohol on the human being, its physiological and pathological action. That alcohol is abused as a therapeutic agent is only too clear; there are extremists in the teetotal wing of the medical profession and there are those who find in alcohol a panacea for all ills. The unreason of both sections is unscientific, and positively prejudicial to the best interests of medicine. We heartily wish this temperance movement success, but we fear that the publication of such hysterical writing as that before us is one of the greatest obstacles to the progress of the temperance movement. There is a temperance in writing and speaking as well as in drinking.

#### NEW BOOKS AND NEW EDITIONS.

The following have been received since the publication of our last list:—

BAILLIÈRE, TINDALL, AND COX (London).

A Manual of Surgery for Practitioners and Students. By Wm. Rose, M.B. Lond., F.R.C.S., and Albert Carless, M.S. Lond., F.R.C.S. 4th Edition. University Series. Pp. 1182, with xix. plates and 406 woodcuts. Price 21s.

The Diagnosis and Treatment of Diseases of the Rectum. By Herbert Wm. Allingham, F.R.C.S., and Herbert W. Allingham, F.R.C.S. 7th Edition. Pp. 582, with 69 illustrations. Price 12s. 6d.

The Pocket Gray or Anatomist's Vade Mecum. 5th Edition. Revised and Edited by C. H. Fagge, M.B., M.S. Lond., F.R.C.S., Pp. 289. Price 3s. 6d.

A Handbook of Diseases of the Nose and Pharynx. By Jas. B. Ball, M.D. Lond. 4th Edition. With 61 illustrations. Price 7s. 6d.

Syphilis and Other Venereal Diseases. By H. de Meric, M.B.C.S. Pp. 132. Price 5s.

CASSELL AND CO., LIMITED (London).

Surgical Diseases of the Kidney and Ureter. By Henry Morris, M.A., M.B. Lond., F.R.C.S. In two volumes. Price 42s.

J. AND A. CHURCHILL (London).

A Text-book of Medicine. By the late Dr. C. Hilton Fagge. Edited by P. Henry Fyfe-Smith, M.D., F.R.S. 4th Edition. Vol. I. Pp. 1117. Price 21s.

A Manual of Minor Surgery and Bandaging. By Christopher Heath, F.R.C.S., LL.D. 12th Edition, revised by Bilton Pollard, F.R.C.S. Pp. 426. Price 6s. 6d.

H. K. LEWIS (London).

The Sanitary Inspector's Handbook. By Albert Taylor. 3rd Edition. Pp. 406. Price 6s.

LONGMANS, GREEN AND CO. (London).

A Practical Guide to the Administration of Anæsthetics. By E. J. Probyn-Williams, M.D. Pp. 211. Price 4s. 6d.

Memoirs and Letters of Sir James Paget. Edited by his son, Stephen Paget, F.R.C.S. With portraits and other illustrations. Pp. 438. Price 12s. 6d.

Anatomy, Descriptive and Surgical. By Henry Gray F.R.S. 15th Edition, edited by T. Pickering Pick, F.R.C.S., and Robert Howden, M.A., M.B., C.M. Pp. 1086. Price 32s.

MACMILLAN AND CO., LIMITED (London).

A Manual of Determinative Bacteriology. By Frederick D. Chester. Pp. 401. Price 10s. 6d.

JOHN MURRAY (London).

Handbook of Physiology. By W. D. Halliburton, M.D., F.R.S. 4th Edition. Pp. 888. Price 14s.

GRAFT RICHARDS (London).

The Revival of Phrenology, the Mental Functions of the Brain." By B. Hollander, M.D. Freiburg, M.B.C.S. Pp. 1,512. Price 21s.

THE SCIENTIFIC PRESS, LIMITED (London).

Tendencies to Consumption: How to Counteract Them. By J. D. E. Mortimer, M.B., F.R.C.S. Pp. 138.

STRANGEWAYS AND SONS (London).

Clinical Pathology and Practical Morbid Histology. By T. Strangeways Pigg, M.A. Pp. 107.

G. STEINHEIL (Paris).

Anatomie Générale Appliquée à la Physiologie et à la Médecine. Par Lavier Bichat. Parts 1 and 2. Pp. 604. Price 4s.

JOHN WRIGHT AND CO. (Bristol).

Kitchen Physic at Hand for the Doctor and Helpful for Homely Cures. By W. T. Farnie, M.D. Pp. 586. Price 6s.

Pulmonary Tuberculosis, its Prevention and Cure. By Prof. Carlo Busta, M.D. Pp. 143. Price 3s.

## Literature.

### PHILLIPS' OUTLINES OF DISEASES OF WOMEN. (a)

THIS work has now reached its third edition, and while several paragraphs on fibromyomata and ectopic gestation have been re-written and an excellent summary of the bacteriology of the genital tract has been added to the book we think that a more thorough revision throughout would have greatly increased its value. There are many excellent prescriptions throughout the text which will be of valuable assistance to the practitioner, and, what is very important in a work of this class, a capital index.

There are many points, however, on which we differ from the author. The left lateral is the position favoured for examination, the hips being covered with a sheet; inspection presumably being necessary only if the patient complains of "being tender." It is also recommended to pass the catheter "without exposure of the patient," and though one is instructed to wash the instrument in 1-1,000 sublimate or 1-40 carbolic in order to avoid the risk of cystitis nothing is said as to the advisability of washing the urethral orifice or separating the labia, which may be covered with a septic discharge. To counteract this modesty, however, under Uterine displacements the author says: "If necessary examine her in the erect posture," but gives no indication for this ultra-scientific procedure.

While quite agreeing that "the too frequent use of the sound cannot be sufficiently deprecated," we think that many of the evil results caused by the sound are due to insufficient attention being given to asepsis, both of the patient and instrument, and here again we consider false modesty is to blame, the advice "when possible, especially if a purulent or offensive discharge is present administer an antiseptic douche" is not sufficient.

There is a good chapter on menstruation, the various theories as to its nature and causation being clearly explained, but we cannot follow the author when he

(a) "Outlines of the Diseases of Women." By John Phillips, M.A., M.D., F.R.C.P., &c. Third Edition. Pp. 280. London: Charles Griffin and Co., Ltd.

explains the effect of hot douches in premenstrual dysmenorrhœa as causing "a constriction of the vessels at the bases of the broad ligaments, and so" relieving congestion.

We quite agree with the condemnation of the hysterotomy and expanding dilators, and we think that sponge tents and the *écraseur* which is recommended for the removal of a hypertrophic elongation of the cervix and intra-uterine growths might well have been added to the list.

The treatment of sub-involution of the uterus is explicit; but after recommending douches, drugs, &c., "and if the patient's means allow of a visit to" one of the foreign spas, the author says:—"If, in spite of the above courses of treatment, the symptoms, especially hæmorrhage or the presence of offensive discharge go on, and the patient's general health is suffering, an examination of the interior of the uterus is necessary." (The italics are ours.) We think that this examination might, with great benefit to the patient's health and pocket, be made at an earlier period.

#### SEWILL'S DENTAL SURGERY. (a)

THE fourth edition of this book on dental surgery, which has just reached us, fully maintains the character of the work as a concise elementary hand-book. Its increase in size on the last edition is in keeping with the rapid progress which has been made in dental science during the last ten years, each chapter having been re-written and amplified. It has been carefully edited, the language is simple and clear, and no effort has been spared to make it a thoroughly practical manual.

We note with pleasure the clear and exhaustive chapter on "Caries and its Sequelæ in Infancy and Early Childhood." There is no part of dentistry which in the past has been more consistently overlooked, both by parents and dentists, than the care of children's teeth. Without endorsing every point of treatment, particularly the opinion expressed regarding the inadvisability of capping pulps in the milk teeth, we think the subject well handled as regards the preservation of the temporary teeth themselves and their influence on their permanent successors.

Oral sepsis as a cause of local and systemic disease, deserves more notice from the general practitioner than it usually gets, and the author's references to the observations of Mr. Watson Cheyne, Dr. Hunter, and others, regarding the connection between carious teeth and tuberculous cervical glands are cogent enough to repay anyone who may read them.

The author's summary of and conclusions regarding the ætiology and pathology of caries are both comprehensive and searching, and show a very thorough investigation of this important subject. His just condemnation of many of the absurd theories which from time to time have been advanced to account for this dental lesion must meet with the approval of every thinking pathologist. Let us hope that his sarcastic footnote to pages 244 and 245 will at least tend to check the meandering of the "impressionist" pathologist in regions where "a little knowledge is" so evidently "a dangerous thing."

Mr. Sewill's dicta regarding pyorrhœa alveolaris are unfortunately very wide of the mark, and cannot, in the light of recent investigations, be held to be even approximately correct.

The chapter on pivot teeth (which is made to include crown-bar and bridge work) is disappointing. It seems almost a pity that it should have been written, because the subject is so large that no adequate idea of the function of crown work and allied prosthetic devices in dentistry can be given in the few pages which have been devoted to it. To the student of dentistry it is of little value, for while describing in a categorical manner a few of the crowns in use, and these are not representative, it makes no

attempt to classify them according to their spheres of applicability—surely a matter of prime importance. No full indication is given of when and when not to crown or bridge, and altogether the medical as well as the dental student is more mystified than otherwise by its perusal. It is to be hoped that in a future edition this chapter may be better illustrated, amplified, and brought up to date, or else omitted entirely.

The question of porcelain inlaying, and other fillings is ably treated. The chapters on anatomy, histology, and development are particularly well written.

Despite the few blemishes above noted, Mr. Sewill and his editors are distinctly to be congratulated on the result of their collaboration.

#### HEWITT'S ANÆSTHESIA. (a)

THIS, the second edition of Dr. Hewitt's book, is practically a new book. No person is more competent to write of the subject, considering his great practical experience in the administration of anæsthetics and his familiarity with the literature of the modern experimenters and practical anæsthetists.

The book consists of over 500 pages of royal octavo, clearly printed on good paper, profusely illustrated and well-indexed. His arrangement of the matter is excellent. He commences with the history of anæsthesia; then deals with considerations before anæsthetisation; the chapter on administration naturally follows; then the treatment of the accidents and so forth incidental to administration are dealt with, and the concluding part deals with the condition of the patient after administration. In the production of the book he had the friendly co-operation of Dr. L. Hill, who with Mr. H. Candy, scrutinised all his chemical statements; and that of Mr. Bellamy Gardner, "who spent much time in collecting and comparing all the available facts bearing upon the history of anæsthesia."

Withal the book is disappointing. The scheme, the co-operation, the great practical experience of the author, raises hopes of an almost ideal book; yet, like the statue of the Babylonish king, its feet are of clay. Documents dealing with the history of anæsthetics may have been collected and compared by Mr. Bellamy Gardner very carefully, and we do not say they have not. But with the history as given by Mr. Hewitt we deal, and to us it reads as if original papers on the subject were not consulted by the author. To point out his errors would be to re-write the article. He tells us of Dr. Long and his assistant. Dr. Long in 1842 had no assistant. He further states that Long had taken no steps, prior to Morton's time, to make his discovery known—which is incorrect. He notices that the use of nitrous oxide was discontinued, but gives no explanation of its disuse. He refers to Cotton's visit to Paris, and says nothing of Well's visit to Cotton. We read that Morton got a patent for "Lethon." Morton sought a patent for it, and in preventing him getting one Dr. Arthur Jacob bore no small part, as the editorial columns of THE MEDICAL PRESS AND CIRCULAR bear witness.

Of the operation in the Massachusetts Hospital the account is neither accurate nor full. It is very unfortunate that a history so full of error should be placed in the hands of students. In a third edition we hope the history will be either omitted or re-written.

When we pass from this portion of the book we come to some good, useful writing, in which, however, the author's bias in favour of ether appears. He writes with great clearness on the method of administration of ether, and provides an excellent text-book for those whose general anæsthetic is ether. Nothing is forgotten, from the examination of the patient to his complete recovery from the anæsthetic. Of course ether is not to be looked on as a lethal agent, though careless administrators sometimes meet with deaths under ether and unsuitable patients die from its effects. He discusses the different apparatus for administering chloroform, and gives excellent advice as to the use of

(a) "Manual of Dental Surgery, including Special Anatomy and Pathology." By Hy. Sewill. M.B.C.S., L.D.S. 4th Edition. Edited by W. J. England, L.D.S. Eng., and J. Sefton Sewill, M.B.C.S., L.D.S. Pp. 622. With 281 Illustrations. Price 10s. 6d. net. London: Baillière, Tindall and Cox. 1901.

(a) "Anæsthetics and their Administration. A Text-Book for Medical and Dental Practitioners and Students." By Frederick W. Hewitt, M.A., M.D. Cantab., Anæsthetist to His Majesty the King. With Illustrations. London: Macmillan and Co., Limited. 1901.

the drop bottle and Skinner's mask; but we think he over-estimates the consumption of chloroform by the mask as a drachm every four or five minutes; given on cotton web, we have never found it consume half the amount.

When we come to consider the physiological action of chloroform we come on debatable ground. Dr. Hewitt holds that chloroform is a direct cardiac depressant, and bases his argument to show its markedly lethal properties on the "cross-current" Cambridge experiment. We have no wish to enter on this ground. We think a scientific question is quite capable of being discussed calmly; the *odium theologicum* should find no place in science. We therefore rest content with giving a quotation from Dr. Gaskell's letter to Dr. Lawrie, which letter Dr. Lawrie read at the Montreal meeting of the British Medical Association in September, 1897:—"The ligature on the subclavian of the right side proximal to the vertebræ, which was the only ligature on that side, was in the right position, but was not tight, so that the injection was able to pass both into the vertebræ and into the area of that side.

#### AULD'S PATHOLOGY. (a)

AN author's writings are always of most value and usually of greatest interest when considered in their relationships. Only too frequently much of an investigator's results lie scattered through many publications; it is well, therefore, that all likely to be of service to other workers should be collected and arranged by the hand that wrought. We therefore think that Dr. Auld has done wisely to bring together a number of important papers which originally appeared in journals and transactions, and presenting them in convenient and, as literary material goes, permanent form. Although the freshness associated with new work is not here, there is much that is worth careful perusal. All has, however, been thoroughly revised, and, in some instances, new matter added.

The essays treat of emphysema, pneumonia, Bright's disease, hæmatogenous jaundice, and Addison's disease. The most important and valuable article in the whole book is that published in collaboration with the late Professor Coats, on atheroma and aneurysm. Within the compass of a short review it is impossible to deal with all the subjects which are presented. In spite, however, of a somewhat involved style, and occasionally loose method of expression, there is much that is suggestive and likely to stimulate further research. The investigations concerning the toxic effects of the chemical products of the pneumococcus are particularly valuable and will probably prove of practical service. The chemical and experimental work in connection with Addison's disease is also on promising lines.

In too many instances the author seems to have lacked the grasp which plucks from Nature's secrets the tangible flower of a definite conclusion, but with pathological problems this, in all fairness, can hardly be laid to him as a fault. The articles are well arranged, the illustrations are clear, and the printing and general get-up of the work excellent.

#### HERMAN ON DIFFICULT LABOUR. (b)

THIS handy volume, with its 165 admirable illustrations has been completely revised, important alterations have been made in the chapters dealing with Cesarean Section and Symphysiotomy, and special attention has been given to bringing the technique as up-to-date as possible. The author's style is undoubtedly dogmatic, and he deals with his subject in a clear, concise manner, which cannot but be appreciated by both students and busy practitioners.

His dogmatism sometimes leads him a little too far. For example, in dealing with the treatment of face presentation, he says, "If it be possible to change the face presentation into a vertex this should be done."

(a) "Selects Researches in Pathology." By Alex. Gunn Auld, M.D., M.B.C.P. Pp. 153. With 13 Illustrations. London: J. and A. Churchill. 1901.

(b) "Difficult Labour: a Guide to its Management for Student and Practitioners." By S. Ernest Herman, M.B.Lond., F.R.C.P. New and Revised Edition. 1901. London: Cassell and Co., Ltd.

We cannot accept this as good treatment in cases where the face lies in the right oblique diameter with the chin anterior, to follow the author's advice you would convert a favourable face presentation into an unfavourable vertex. His directions for the treatment of accidental hæmorrhage at term are based on theoretical possibilities which are unfortunately seldom borne out in practice. His condemnation of plugging the vagina as "a clumsy and painful way of irritating the cervix and stimulating the uterus to contract" is not warranted in the light of the recent splendid results following this method of treatment. We are glad to recognise that in the treatment of rupture of the uterus his conclusions are identical with those of Merz which appeared in the *Arch. f. Gyn.*, Bd. XIV., inasmuch as he recommends drainage. Differences of opinion are inevitable in a work of this class. Nevertheless, we cannot but congratulate Dr. Herman on the excellence of the work here brought together in "Manual" form, and the publishers also on the way they have turned it out.

#### THE CARICA PAPAYA. (a)

IT must be admitted that the *Carica papaya* has never taken a very prominent place as a therapeutical agent, although its pharmacological action has been worked out with much care by many competent observers. The whole subject of the digestive ferments is full of interest, and, considering the prevalence of functional disorders of the stomach among all civilised people, and especially among those who are brain-workers and lead a sedentary life, it is surprising that artificial aids to digestion are so rarely prescribed. It may be that their mode of preparation is imperfect, or that their action is uncertain; but undoubtedly many of them—the Papaw among others—have fallen into undeserved neglect. The author of this very instructive paper, which is reprinted from the *American Journal of Pharmacy*, speaks as one having authority, and there is evidence that he has devoted much time and attention to the subject. He goes into the history of the drug thoroughly, and traces it from its source to the finished product. He does not write as an enthusiast, and seems to have no desire to unduly advocate the merits of the drug, but presents us with a contribution which will be read with interest.

#### Medical News.

##### Plague at Naples.

BUBONIC plague is reported to have broken out among the dock labourers at Naples. Up to the present some twelve cases have been certified, of which several have ended fatally. The origin of the outbreak is attributed to a vessel from an Indian port.

##### A Well-directed Prosecution.

THE wife of a tradesman in North London was fined last week for having made certain false statements in registering the birth of a child, in order, as was admitted, to avoid the obligation of allowing the child to be vaccinated.

##### Fatal Circumcision.

AN inquest was held at the London Hospital last week on an infant, eight weeks of age, who had succumbed to hæmorrhage following circumcision performed at that institution. There is nothing in the evidence to suggest that the child was the subject of hæmophilia and it is difficult to exonerate those in charge from blame for allowing the loss of blood to become dangerous. A verdict of death from misadventure was returned.

##### London Hospital Medical College Scholarships.

THE following Entrance Scholarships have been awarded at the London Hospital Medical College. Price Scholarship in Science, value £120, Mr. J. Owen; Price Scholarship in Anatomy and Physiology (open to students of Oxford and Cambridge only), value £80, Mr. Theo Thompson; Entrance Science Scholarship, value

(a) "The Story of the Papaw." By F. B. Kilmer. Philadelphia 1901.



£80, Mr. A. H. Pollard; Entrance Science Scholarship, value £35, Mr. E. H. R. Harries; Epsom Scholarship, value £126, Mr. S. H. Scott.

#### St. Thomas's Hospital Medical School.

THE Entrance Scholarship in National Science, of the value of £150, has been awarded to Harold Beckwith Whitehouse, and the University Scholarship, of the value of £50, to George Rammell Footner, B.A., of Pembroke College, Cambridge.

#### Open-air Sanatoria.

OPEN-AIR sanatoria, now becoming so generally popular in Europe, are said to owe their origin to Miss Florence Nightingale. This notable woman first cured M. Benet, of Mentone, by advising him to pass the better part of his time out of doors, to reject medicines, and to apply himself to a liberal diet. The first establishment devoted to the open-air cure was founded at Gœrbersdorf in 1859 by Hermann Brœhmer, though it was left to his disciple and pupil Dettweiler to perfect the theory in the course adopted in 1875 at the sanatorium of Falkenstein. There are now in the Valley of Davos about 3,000 patients and sixteen physicians.

#### Disease Transmitted by Ants.

AN English doctor residing in Cyprus has encountered remarkable cases of disease being transmitted in the sting of the solitary ant. In one instance a woman was stung in her sleep by one of these insects, and the wound showed active signs of anthrax infection. It was then found that in the field adjoining her cottage there was a dead sheep, which had lain there for a week since it succumbed to that disease. Here, then, is yet another insect to be added to the growing list of those that, while not dangerous in themselves, are capable of great mischief owing to their transmission of malignant bacilli.

#### War Against Malaria.

THE Italians have determined to eliminate malaria from the Peninsula, if possible. Active prophylactic measures were taken during the summer and autumn, and are to be continued, against the disease. Stations for observation and experimentation have been instituted in the provinces of Rome, Milan, Cremona, Mantua, and Foggias. Prophylactic experiments are being conducted along the littoral of Eumelia. In all the paludal regions the municipalities are taking part in the experiments to stay the propagation of the hæmatozoon.

#### Vital Statistics.

THE deaths registered in the week ending September 21st in 36 large towns of Great Britain and Ireland corresponded to an annual rate of 21·3 per 1,000 of their aggregate population, which is estimated at 11,463,026 persons in the middle of this year:—

Birkenhead 12, Birmingham 17, Blackburn 15, Bolton 20, Bradford 17, Brighton 14, Bristol 11, Burnley 25, Cardiff 13, Croydon 17, Derby 11, Dublin 23, Edinburgh 15, Glasgow 16, Gateshead 22, Halifax 17, Huddersfield 19, Hull 15, Leeds 16, Leicester 15, Liverpool 19, London 15, Manchester 19, Newcastle-on-Tyne 20, Norwich 16, Nottingham 18, Oldham 20, Plymouth 15, Portsmouth 17, Preston 20, Salford 20, Sheffield 19, Sunderland 25, Swansea 11, West Ham 18, Wolverhampton 13. The highest annual death-rates per 1,000 living, as measured by last week's mortality, were:—From scarlet fever, 1·0 in Derby; from whooping-cough, 1·1 in Swansea; from "fever," 1·6 in Salford, and 2·2 in Huddersfield; and from diarrhoeal diseases, 3·7 in Hull, 4·0 in Sheffield, 4·1 in Newcastle-on-Tyne, 4·3 in Sunderland, 5·4 in Burnley, and 6·6 in Gateshead. In none of the large towns did the death-rate from measles reach 1·0 per 1,000.

#### Death from Alcoholic Poisoning.

A CHILD, age three, died at the Wolverhampton Hospital a few days since as the result of drinking a quantity of brandy which had been left within her reach. Remedial measures proved unavailing, the child being unconscious when discovered.

#### The Mortality in Foreign Cities.

THE following are the latest official returns, and represent the last weekly death-rate per 1,000 of several of

the populations:—Calcutta 25, Bombay 61, Madras 91, Paris 15, Brussels 14, Amsterdam 13, Copenhagen 21, Stockholm 14, Christiania 12, St. Petersburg 24, Moscow 30, Berlin 22, Hamburg 18, Breslau 23, Munich 19, Vienna 15, Prague 18, Buda-Pesth 15, Trieste 21, Rome 17, Venice 18, Cairo 58, Alexandria 48, New York (including Brooklyn) 20, Philadelphia 16.

#### The Gaol after the Workhouse.

ERNEST RICHARD EVANS, described as a medical practitioner, was sentenced to a month's hard labour last week, at the North London Police Court, for absconding from the Hackney Union Workhouse with a suit of clothes, &c., the property of the guardians.

#### Zymotic Disease in London.

THE hospitals of the Metropolitan Asylums Board on Saturday last contained 3,106 patients suffering from scarlet fever, 1,474 from diphtheria, and 170 from small-pox. The last-named disease continues to spread in a quiet, unostentatious way, each day bringing its quota of cases.

LAST Sunday being the sixth anniversary of the death of Dr. Pasteur, the disciples of the scientist, headed by Dr. Metchnikof, visited the crypt of the Pasteur Institute, where a memorial ceremony took place. At the same time M. Decrais, the Minister for the Colonies, presided at the unveiling of a statue in the principal square of Arbois, where Pasteur passed his childhood. Pasteur is represented as sitting in an arm-chair, in the attitude of enunciating to his audience some new departure in scientific research.

## Pass Lists.

### University of Durham.

THE following candidates have satisfied the examiners in the first examinations for the degree of Bachelor in Medicine:—

#### Old Regulations.

Chemistry, with Chemical Physics.—S. Mankar, L.S.A., Lond. Hosp.

#### New Regulations.

Elementary Anatomy, Chemistry, and Physics.—Honours, Second Class: R. J. Douglas, St. Bart's. Pass List: J. H. Cooke, B. Litt, W. Cowden, A. B. Jones, W. E. C. Lunn, and R. G. S. Simpson, Coll. of Med., Newcastle.

Chemistry and Physics.—R. Begg, M.R.C.S., St. Bart's.; J. B. Cooke, Coll. of Med., Newcastle; S. J. Fielding, St. Thomas's; A. Finlay, Lond. Hosp.; J. S. Gibb, St. Bart's.; E. V. Khedkar, Grant College, Bombay; C. C. Lavington, E. L. Markham, and F. H. Moron, Coll. of Med., Newcastle; E. W. Pearson, M.R.C.S., Owens College; A. J. Turner, Lond. Hosp.; E. Tate and Tys Visser, Coll. of Med., Newcastle.

Elementary Anatomy and Biology.—H. B. Cunningham, S. L. McBean, and Jno. C. Norman, Coll. of Med., Newcastle.

Elementary Anatomy.—T. H. Bishop, Edin. Univ.

The following candidates have satisfied the examiners in the second examination for the degree of Bachelor in Medicine:—

#### Old and New Regulations.

Anatomy, Physiology, and Materia Medica.—Honours, First Class: J. G. O. H. Lane, M.R.C.S., L.R.C.P., Guy's Hosp.; T. W. Maddison, Coll. of Med., Newcastle. Honours, Second Class: G. E. Lloyd, Coll. of Med., Newcastle.

Pass List: J. A. Bell, St. Bart's.; L. A. H. Bulkley, A. Budd, H. M. Braithwaite, and H. Christal, Coll. of Med., Newcastle; E. F. Edmunds, Univ. Col., Sheffield; H. E. Featherstone, A. H. Hogg, and N. H. Hume, Coll. of Med., Newcastle; W. W. Jones, Bgham. Univ.; Sophia B. Jackson, Univ. Coll., Cardiff; F. W. Kemp, Coll. of Med., Newcastle; A. V. Maybury, Guy's; C. F. F. McDowall and C. Charlotte Robertson, Coll. of Med., Newcastle; L. M. Rosten, St. Bart's.; S. Robson, W. E. Stevenson, and W. Seymour, Coll. of Med., Newcastle; F. R. Snell, St. Thomas's; A. L. Sheppard, W. T. Sitwell, F. J. Strachan, and W. L. Tindle, Coll. of Med., Newcastle; S. G. Webb, Bgham. Univ.

## Notices to Correspondents, Short Letters, &c.

✉ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

M.R.O.—Stimulants should be freely given in cases of carbolic acid poisoning, and their action may advantageously be reinforced by the subcutaneous injection of caffeine or strychnine in the hope of obviating the depressing effect of the poison on the cardiac function.

L. R.—We have no means of ascertaining the merits of the dispute, of which we prefer to leave the settlement to the bodies immediately concerned.

Dr. E. M. S.—We are unable to publish your paper, as it has already appeared, in great part, in a contemporary.

MESSEURS. ROBIN (PARIS).—It is not for us to offer an opinion as to the chances of success your pills might have in this country. If the active principle which you have succeeded in isolating really possesses the admirable properties which are claimed for it, we would advise you to have it brought before the profession in the usual way, certainly not by means of advertisements in the lay press.

Dr. SELIN.—The responsibility for the statement rests with the correspondent who made it. We are obviously unable to verify other people's references in every instance. It is, of course, open to you to challenge its accuracy or its application.

### THE STATISTICS OF THE IRISH HOSPITAL IN SOUTH AFRICA.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In your issue of September 18th you were good enough to publish a paper of mine on "Medical Experiences in South Africa." In the original MS. and in the proof which I returned to you the total enteric mortality was correctly given as 11·7 per cent. In your issue of September 18th the total enteric mortality was printed as 18·7 per cent.

I wrote to point out the inaccuracy, and in your issue of September 25th the following appears:—

"We hasten to correct an error which in some curious manner seems to have crept into Dr. Coleman's article on "Medical Experiences in South Africa," which appeared in our last issue. The total mortality among the cases treated in the Irish Hospital was wrongly given as 18·7 per cent. It should have been 11·7 per cent., a very material difference."

The error, though "curious," is not mine, and it is supplemented by a farther blunder. "The total mortality among the cases treated in the Irish Hospital" was 3·7 per cent. (102 deaths in 2,749 cases), while the total enteric mortality to which I referred in my paper was 11·7 per cent. (79 deaths in 672 cases).

I am, Sir, yours truly,  
J. B. COLEMAN, M.D.

9, Merrion Square,  
Dublin, September 26th, 1901.

## Meetings of the Societies.

FRIDAY, OCT. 4TH.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY (West London Hospital, Hammersmith Road, W.).—8.30 p.m. Mr. A. Cooper (President): Inaugural Address.

WEST KENT MEDICO-CHIRURGICAL SOCIETY (Royal West Kent Dispensary, Greenwich Road, S.E.).—8.45 p.m. Clinical Evening. Dr. Toogood: Cases from Lewisham Infirmary.—Dr. Scholefield: Clinical Cases.—Dr. Dockrell: Dermatological Cases.

TUESDAY, OCT. 8TH.

SOCIETY FOR THE STUDY OF INEBRITY.—At 4 p.m. The Quarterly Meeting (rooms of the Medical Society of London), 11, Chandos Street, Cavendish Square, when papers will be read by Mr. Charles Smith, of Maidstone; by Dr. Martyn Westcott, and by the President.

## Appointments.

BEESEY, ROBERT W., M.D., C.M., M.R.C.P. Edin., M.R.C.S. Eng., L.R.C.P. Lond., Honorary Medical Officer to the Bolton Infirmary and Dispensary.

BYER, WILLIAM H., M.B., C.M. Edin., Honorary Medical Officer to the Bolton Infirmary and Dispensary.

BUTT, FRANCIS J., M.B., C.M. Edin., Medical Officer of Health of Hoole Urban District.

GORDON, THOMAS E., M.D. Durh., M.R.C.S. Eng., Medical Officer of Health of Towyn Urban District.

JOHNSON, H., L.R.C.P. Edin., L.R.C.S. Edin., L.F.P.S. Glasg., Medical Officer of the South District of the Lincoln Union.

JOHNSON, WILLIAM CROSSBY, M.B., Ch.B. Vict., Junior House Surgeon to the Salford Royal Hospital.

ROBERTSON, GEORGE, L.R.C.P., L.R.C.S. Edin., L.F.P.S. Glasg., Certifying Surgeon under the Factory Acts for the Kirkpatrick Durham District of Kirkcudbrightshire.

SCOTT, BERNARD, M.R.C.S. Eng., Assistant Medical Officer of the West Bromwich Workhouse.

WILSON, WALTER R., M.B., B.C. Cantab., Honorary Surgeon to the Doncaster Infirmary.

YOUNG, ARCHIBALD, J., L.R.C.P., L.R.C.S. Edin., L.F.P.S. Glasg., Medical Officer of Health of the Whitefield Urban District.

## Vacancies.

Burton-on-Trent Infirmary.—House Surgeon Salary £120 for the first year and £140 for the second year, with board, furnished rooms, coal, and light. Applications to the Hon. Secretary.

Clayton Hospital and Wakefield General Dispensary.—Senior House Surgeon, unmarried. Salary £120 per annum, with board, lodging, and washing. Applications to the Hon. Secretary.

County Asylum, Mickleover, Derby.—Senior Assistant Medical Officer. Salary £130, rising to £150 per annum, with apartments, board, washing, and attendance. Applications to the Medical Superintendent.

Hertfordshire County Asylum, Hill End, St. Albans.—Junior Assistant Medical Officer, unmarried. Salary £160 a year, with board, furnished apartments, and washing. Applications to the Medical Superintendent.

Manchester Children's Hospital, Pendlebury.—Medical Officer. Salary £180 per annum. Applications to the Secretary.

Midlothian District Asylum.—Assistant Medical Officer, single. Salary £200, with furnished rooms, board, washing, and attendance.

North Staffordshire Infirmary and Eye Hospital, Hartshill, Stoke-upon-Trent.—House Physician. Salary £100 per annum, increasing £10 per annum, with furnished apartments, board, and washing.

North Wales Counties Lunatic Asylum, Denbigh.—Second Assistant Medical Officer. Salary £120 per annum, rising to £160, with board, residence, and washing. Applications to the Clerk of the Visiting Committee.

St. Mary's Hospital Medical School, Paddington, W.—Curator of Museum and Assistant Pathologist. Salary £100 per annum. Full particulars on application to the Dean.

Stirling District Asylum, Larbert, N.B.—Junior Assistant Medical Officer. Salary £100, with board, &c.

## Births.

MARTIN.—On September 24th, at 59, High Street, Chelmsford, the wife of John L. Martin, M.B., C.M., of a daughter.

WILLIS.—On September 24th, at 57, Sundays Well, Cork, the widow of Surgeon J. P. Willis, M.B., B.N., late of H.M.S. St. Vincent, Portsmouth, of a daughter.

## Marriages.

GLASIER—FIELD.—On September 26th, at Benhilton Church Sutton, Surrey, Howard Glasier, M.A., M.B., Cantab, younger son of W. R. M. Glasier, of Boyne Lodge, Tunbridge Wells, to Ethel May, youngest daughter of James Frederick Field, of Southwark, and Benhilton Mount, Sutton.

LAW—WILLIAMS.—September 25th, at the Old Parish Church, Hove, Brighton, Herbert Henry, second son of Edmund Law, of Northampton, to Ada Martin, second daughter of the late David Martin Williams, M.B.C.S., formerly Indian Medical Service, and of Mrs. D. M. Williams Pembroke Crescent, Hove.

SAMWAYS—SIM.—On September 26th, at Kensington Chapel, Allen Street, London, W., Daniel West Samways, M.D., M.R.C.P., D.Sc., of Mentone, to Sarah Sophia, widow of the late Captain A. D. Sim, Argyll and Sutherland Highlanders, and youngest daughter of the late J. C. Bolton, of Carbrook, Argyllshire.

## Death.

ARCHER.—On September 20th, at Upper Woburn Place, Francis Bonfield Archer, M.B., C.M., in his 54th year.

OPERATION DAYS AT THE LONDON HOSPITALS.  
MONDAY.—London, 2 p.m.—St. Bartholomew's, 1.30 p.m.—St. Thomas's, 3.30 p.m.—St. George's, 2 p.m.—Ophthalmic, 1.15 p.m.—St. Mark's, 2.30 p.m.—Middlesex, 1.30 p.m.—St. Mark's, 2 p.m.—Chelsea, 2 p.m.—Samaritan (Gynaecological by Physicians), 2 p.m.—Soho Square, 2 p.m.—Royal Orthopaedic, 2 p.m.—City Orthopaedic, 4 p.m.—Great Northern Central, 2.30 p.m.—West London, 2.30 p.m.—Westminster, 2 p.m.  
TUESDAY.—London, 2 p.m.—St. Bartholomew's, 1.30 p.m.—Guy's, 1.30 p.m.—St. Thomas's, 3.30 p.m.—Middlesex, 1.30 p.m.—Westminster, 2 p.m.—West London, 2.30 p.m.—University College, 2 p.m.—St. George's, 1 p.m.—St. Mary's, 1 p.m.—St. Mark's, 2.30 p.m.—Cancer, 2 p.m.  
WEDNESDAY.—St. Bartholomew's, 1.30 p.m.—University College, 2 p.m.—Royal Free, 2 p.m.—Middlesex, 1.30 p.m.—Charing Cross, 3 p.m.—St. Thon's, 2 p.m.—London, 2 p.m.—King's College, 2 p.m.—St. Mary's, 2 p.m.—National Orthopaedic, 10 a.m.—St. Peter's, 2 p.m.—Samaritan, 2.30 p.m.—Gt. Ormond St., 9.30 a.m.—Gt. Northern Central, 2.30 p.m.—Westminster, 2 p.m.—Cancer, 2 p.m.  
THURSDAY.—St. Bartholomew's, 1.30 p.m.—St. Thomas's, 3.30 p.m.—University College, 2 p.m.—Charing Cross, 3 p.m.—St. George's, 1 p.m.—London, 2 p.m.—King's College, 2 p.m.—Middlesex, 1.30 p.m.—St. Mary's, 2.30 p.m.—Soho Square, 2 p.m.—North-West London, 2 p.m.—Chelsea, 2 p.m.—Gt. Northern Central (Gynaecological), 2.30 p.m.  
FRIDAY.—London, 2 p.m.—St. Bartholomew's, 1.30 p.m.—St. Thomas's, 3.30 p.m.—Guy's, 1.30 p.m.—Middlesex, 1.30 p.m.—Charing Cross, 3 p.m.—St. George's, 1 p.m.—King's College, 2 p.m.—St. Mary's, 2 p.m.—Ophthalmic, 10 a.m.—Cancer, 2 p.m.—Chelsea, 2 p.m.—Gt. Northern Central, 2.30 p.m.—West London, 2.30 p.m.—Cancer, 2 p.m.  
SATURDAY.—Royal Free, 9 a.m. and 2 p.m.—Middlesex, 1.30 p.m.—St. Thomas's, 2 p.m.—London, 2 p.m.—University College, 9.15 a.m.—Charing Cross, 3 p.m.—St. George's, 1 p.m.

# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXIII.

WEDNESDAY, OCTOBER 9, 1901.

No 15.

## Paris Clinical Lectures.

### TINEA TONSURANS.

By PROF. BALZER, M.D.,

Professor of Dermatology.

UNDER the name of tinea tonsurans many very different affections of the scalp caused by various kinds of parasites are comprised. The trichophyton tonsurans discovered in 1844 by Gruby and Malmstein is the most important of these by reason of its frequency. Of the others, the one most commonly met with is the microsporon Audouinii, which has been investigated of recent years by M. Sabouraud. This parasite may invade the scalp and the neighbouring tegument, and it produces a particular form of tinea tonsurans known under the name of tinea microsporic. This affection is characterised by extremely numerous spores, forming a sort of sheath around the root of the hair. Of a rounded form these spores are composed of a nucleus protoplasm and an episore. They are arranged without order more or less in a mosaic.

The trichophyton also presents several different varieties, but the essential elements are always the same. They are represented by spores roughly resembling those of microsporon Audouinii, viz., a nucleus surrounded by protoplasm and an envelope called episore. These spores may be isolated or arranged in beadlike fashion.

The trichophyton can be easily cultivated in a sweetened liquid, beer, must, &c., and presents several varieties, of which the most important is that described by M. Sabouraud under the name of trichophyton endothrix, that is to say, characterised by its seat in the body of the hair. It presents two varieties according as the mycelium is affected or not by caustic potash (40-100), which is employed in examining it, viz., the T.E., with resisting mycelium and the T.E. with fragile mycelium. The former is peculiar to England, and is rarely seen in France, where the latter exists on the contrary in great abundance. This is the form we observe daily, and to which I wish to draw your attention as well as to the trichophyton ectothrix, a very rare parasite of animal origin, while the two former are invariably derived from human beings, and are propagated from one to another.

Let us now discuss the clinical signs of these different varieties of tinea. We will deal first the tinea tonsurans with small spores, constituted by the microsporon Audouinii.

This variety is very frequently met with in children, especially in Paris, where it occurs in two out of every three cases of tinea tonsurans. It is usually present in a sufficiently characteristic form. If you examine the scalp you will see one or several spots of a rounded or oval shape, generally well-defined, varying in size, and in some cases so numerous as to

invade the whole scalp. On examining closely, with or without the aid of a magnifying glass, we can make out the characteristic sheath of the microsporon surrounding the root of the hair giving it a greyish colour. You will notice, moreover, numerous scales. M. Sabouraud considered that the affection was limited to the scalp, but M. Bécère and other authors have shown that the parasite sometimes attacks the neighbouring tegument of the neck and temporal region.

The microsporic tinea is very common in Paris because it is extremely contagious. On the other hand this form, is perhaps, more easily recovered from than the tinea trichophyton properly so-called. It may even subside spontaneously towards the age of fifteen or sixteen.

We will now pass on to the tinea trichophyton, the form of alopecia determined by the trichophyton endothrix with fragile mycelium. Here the appearance of the spots is quite different from that of the preceding form. The hairs have no sheath; they are sometimes thicker than in the normal state and slightly deformed; but the most characteristic phenomenon is that they break off close to the root. The patches are distributed irregularly, their outline is ill-defined, and they are frequently disseminated in small spots comprising but a few diseased hairs, so that there may be considerable difficulty in arriving at a diagnosis in view of treatment. The malady may also be complicated by seborrhœic eczema, masking more or less its nature; but the broken hairs are always present. They may be withdrawn by the aid of the forceps and examined under the microscope.

The duration of tinea tonsurans is indefinite. Spontaneous cure, though possible, is very rare after the patient has reached twenty years of age.

A curious fact has been observed, viz., that the affection sometimes disappears in the course of a malady associated with high fever. I attended a child some time ago who was suffering from typhoid fever, and who also presented the lesions of tinea. The latter affection got well spontaneously during the course of the fever.

It would seem that high temperature, if sufficiently prolonged, has a destructive action on the parasite.

I now come to the treatment. This comprises epilation and the employment of parasiticides. We must also consider the spontaneous cure of tinea tonsurans under the influence of expulsive folliculitis, which frequently succeeds even in the most rebellious cases.

*Epilation.*—In theory this method appears excellent but it is inadequate in practice, because it is impossible to carry it out in a regular and methodical manner, the hairs breaking off for the most part in the teeth of the forceps. The operation, however, is not without its value in the trichophyton, but it is useless in the tinea microsporic.

**Parasiticides.**—All parasiticides, even those which have any marked action on cultures *in vitro*, are almost powerless when applied to the scalp, because they cannot reach the spores situated in the interiors of the hair or follicles.

**Expulsive Folliculitis.**—In tinea an acute suppurative folliculitis is produced which expels the hair. To cure tinea the same process must be produced artificially, that is to say, folliculitis must be provoked.

**Tinea Microsporic.**—When a child comes suffering from tinea with small spores the first thing to be done is to order the hair to be cut off as closely as possible to the scalp. We can then apply the epilatory paste of hydrosulphate of calcium. This substance is applied in a thick layer and left *in situ* ten or fifteen minutes, then removed under a stream of warm water. The abrasion obtained is superior to that produced by a razor and presents no serious inconvenience. In persons with very sensitive skins there may be some inflammation, but in the majority of cases no inconvenience results. The application of parasiticide agents forms the third phase of the treatment. Of these there is a large selection. The most simple and the most convenient is certainly tincture of iodine painted on morning and evening, and covered with protective plaister. The epilatory paste should be renewed once or twice a week. The treatment is good, and is almost invariably successful, but four or five months will be required to arrive at a complete cure.

Instead of tincture of iodine a more energetic agent called chrysophan traumaticine (1-10) may be employed, especially if the tinea be limited to a small area. For the tinea trichophyton these various measures may be tried, but it is generally necessary to make use of the more active agents which I am about to describe.

**Tinea trichophyton.**—Here epilation is indispensable, and should extend beyond the diseased area. After this operation the parasiticide substances are applied. Recourse may be had to tincture of iodine or to chrysophanic acid, or to carbolic ointment (5 per cent.), or to corrosive sublimate (1 per cent.) applied twice daily. Theraputists have returned of late years to an irritant substance which was originally proposed by Ladreit de la Charrière, and employed by Cadel de Garricourt and Sabouraud, viz., croton oil. The formula of M. Sabouraud is—olive oil, two parts; croton oil, one part. The mixture should be carefully applied exactly over the affected area, and repeated once or twice a week. A crop of pustules is generally the result, rendering extraction of the hairs easier. By reason of its irritant properties, however, this substance cannot be employed in every case, and certain authors refuse to employ it under any circumstances. Other substances may be substituted, such as a 5 per cent. alcoholic solution of resorcine, naphthol ointment (1-10), carbolic oil (1-20), monochlorophenol 3iiss, proof spirit, 3iiss; essence of lavender, 3j. This is applied morning and evening, and covered immediately with oil skin. Such is the treatment of tinea, but, as I have already said, great patience is required by both patient and doctor; to arrive at a complete cure a period of from three to six months being necessary.

In regard to prophylactic measures, they consist in isolating the patient either in the school or at home; the wearing of a cotton cap, easy to wash in boiling water; disinfection of combs and brushes with corrosive sublimate, and the observance of the usual hygienic precautions.

DR. NORMAN MOORE is to deliver the Harveian Or ation at the Royal College of Physicians, on St. Luke's Da y, October 18th.

## A NOTE ON ANTI-TYPHOID INOCULATION IN THE ARMY. (a)

By H. C. DRURY, M.D., F.R.C.P.I.,  
Visiting Physician to Cork Street Fever Hospital; Assistant  
Physician to Sir P. Dun's Hospital, Dublin.

INOCULATION against enteric fever is still upon its trial. It is only in a great organisation like the army that such a measure can be properly tested; where a large number of individuals can be kept under observation for a sufficient time and methodical statistics kept from which to draw trustworthy deductions.

The results of anti-typhoid inoculation in the army in South Africa will be looked for with keen interest. If it comes well out of the terrible ordeal of the early months of 1900 there will be this further regret to be added to those that are gone, that many more of our brave fellows had not received this weapon of defence against the most insidious foe of armies. That thus not only might the lonely veldt have been robbed of hundreds of silent slumberers, but also to thousands might have been spared terrible weeks of suffering under the hard necessities of war.

For the present we must content ourselves with the results obtained by the Army Medical Department in the year 1899, particularly in India.

Enteric is the scourge of the army in India. In spite of all precautions it runs riot, and is a far more grave disease than it is at home. In 1898 it caused 41.4 per cent. of the whole death-rate from all causes among the British Army in India. Of those attacked 27.7 per cent. died, the average for ten years being 26.5 per cent. There were on an average 320 constantly sick from this disease alone. When it is remembered that the average mortality for the twenty years ending 1891 in Cork Street Hospital, Dublin, was 8.6 per cent., it will be seen how vastly more serious enteric fever is in the climate of India.

In 1896 Prof. Wright, of Netley, introduced his anti typhoid serum to the medical profession. It is well for us that it emanated from the Army Medical Department, and was fathered by the energetic Professor of Pathology. The troops, particularly those going abroad, have had the option of inoculation, and a large number of the men availed themselves of it—a sufficiently large number, at least, to make the statistics valuable.

In India, in 1899, there was a diminution in the prevalence of enteric in the army as compared with 1898. According to the report this is considered as at least partly due to inoculation. Several of the stations show interesting statistics. "As Lucknow holds the position of showing the highest average of enteric prevalence during the last ten years, it is of interest to note that even the single inoculations appear to have yielded satisfactory results"—*e.g.*, selecting the two regiments having the largest number inoculated:—The 3rd Hussars, with a strength of 488 had 325 inoculated, 163 not inoculated. Among the inoculated there were 10 cases with 3 deaths, a percentage of 3.08 cases; among the not inoculated, 29 cases with 5 deaths, a percentage of 17.79 cases.

At Bangalore, out of a total strength of 1,538 there were 59 cases of enteric with 12 deaths; 454 were inoculated, and of these only 3 contracted the disease, and all recovered.

At Umballa there were 57 cases and 16 deaths. "About 400 men of the Gordon Highlanders were inoculated with anti-typhoid vaccine by Professor Wright, of Netley. One of these men, who was at

(a) A review of the subject based on the Report of the Army Medical Department for 1899.

the time nursing enteric patients, was admitted three days later for enteric fever, which subsequently proved fatal. He stated that before he was vaccinated he had not been feeling well; evidently he had been sickening for the disease at the time of the inoculation. Excluding this case it appears that the ratio of attack for this regiment was 2.5 per 1,000 among the inoculated, as compared with 40.9 for men not inoculated.

At Ahmednagar there were 55 cases and 9 deaths. Only 14 men were inoculated at this station, and none of these got the disease.

At Mhow there were 49 cases, with 14 deaths. Here 85 individuals were inoculated, but none of these developed the disease.

At Meerut there were 45 admissions, with 17 deaths. Out of the total strength 728 men were inoculated against enteric, of which number 4 contracted the disease, all within four months after inoculation, and 2 died.

At Peshawar there were 41 cases, of whom 16 died. At this station there were only 78 men inoculated, but they all remained free of the disease.

At Agra there were 33 cases with 10 deaths. Here inoculations against typhoid were made in 191 cases. One of these became ill with the disease. He was said to be sickening at the time of inoculation, and the case proved a mild one. No other case occurred among the inoculated men.

At Jhansi there were 33 cases of enteric with 7 deaths. All of these occurred among men who had not been inoculated. Among the 273 men who were inoculated no case of enteric appeared.

At Kirkee there were 32 admissions and 4 deaths; only 36 were inoculated, and 3 of these developed the disease.

At Ranikhet there were 30 cases of enteric, with 5 deaths. No inoculations were carried out at this station, but a considerable number of men quartered there had gone through the operation elsewhere. "Out of 337 men not inoculated and with no previous history of enteric fever, 23 suffered from the disease, while out of a total of 57 inoculated there was not a single case of enteric or anything resembling it. Had the latter body suffered in the same proportion, there should have been 4 or 5 cases among them. All these men were living under precisely similar conditions. If the review is limited to young soldiers in their first year of Indian service, the figures are still more favourable to inoculation, as out of a total of 97 in the 3rd Hussars and Cameronians (again excluding those who had had enteric) 57 non-inoculated men yielded 4 cases of enteric fever, whilst among the remaining 46 who had been inoculated there was not a single case.

At Quetta, 26 cases of enteric fever occurred in the year with 5 deaths; 228 inoculations were carried out, 33 of these having second inoculation. Among these inoculated 3 cases of enteric occurred. All three were very mild, and none of the three were in those who had been twice inoculated.

At Ferozepore 23 enteric cases occurred, with 12 deaths. Only one mild case appeared among the 97 who had been inoculated against the disease.

In the above reports from the stations, only those have been selected in which over 30 cases of enteric occurred, and in which inoculations had been carried out, or already inoculated troops were stationed. The results must be considered to be, if not thoroughly satisfactory, at least extremely encouraging, and cannot be explained away or ignored by a sceptical observer.

The following table is drawn from a similar elaborate one given by the A.M.D. Again India alone is referred to here, as in most of the other stations the numbers are rather small in some particular—either in the number of troops, the number of inoculations,

or the number of enteric cases. For instance, the next most important table for our purpose is that relating to Egypt and Cyprus. There were 4,835 troops, 461 were inoculated, none of these got enteric, but there were only thirty cases of enteric altogether. From the table for India we select only those corps in which 100 or more men were inoculated, and at the end is given the grand total for the whole strength of the army in India.

TABLE SHOWING THE RESULT OF PREVENTIVE INOCULATIONS AGAINST ENTERIC FEVER IN INDIA DURING THE YEAR 1899.

Corps.	Strength.	Number of men inoculated.	Number of men not inoculated.	Cases of enteric fever.				Percentage to strength.			
				Admissions.	Deaths.	Admissions.	Deaths.	Admissions.	Deaths.	Admissions.	Deaths.
3rd Hussars	563	374	179	11	3	32	6	2.94	.80	17.88	3.35
11th Hussars	427	234	193	3	2	10	4	1.28	.85	5.18	2.07
15th Hussars	498	355	143	1	—	3	1	.28	—	2.10	.70
"D" Battery R.H.A.	168	105	63	1	1	1	1	.95	.95	1.59	1.59
2nd Royal Scots	813	198	615	—	—	—	—	—	—	1.79	.49
1st Royal West Surrey Regiment	920	208	712	3	—	11	2	1.44	—	1.54	.28
1st Somerset Light Infantry	960	341	619	6	—	26	5	1.76	—	4.20	.81
2nd Yorkshire Regiment	950	165	785	—	—	18	2	—	—	2.29	.25
1st Scottish Rifles	846	217	629	2	1	18	4	.92	.46	2.86	.64
1st North Staffordshire Regiment	1,087	318	769	6	1	23	3	1.89	.31	2.99	.39
2nd York and Lancaster Regiment	947	171	776	1	—	27	8	.58	—	3.48	1.03
2nd Gordon Highlanders	970	400	570	2	1	29	9	.50	.25	5.09	1.58
3rd Rifle Brigade	947	213	734	—	—	14	2	—	—	1.91	.27
Total for whole Army in India, including above	30,358	4,502	25,851	44	9	657	146	.98	.20	2.54	.56

Having examined the results obtained in the several stations, and now seeing the principal results in the various corps, with the total for the whole of the troops in the command, it must be conceded that in the words of the P.M.O. in India, "The results obtained are very favourable, and would probably have been more so had second inoculations been always practised." He adds "The cases of enteric fever which occurred among the inoculated men, were in the majority of instances of a mild character."

The report says finally: "Other returns received show that, among troops proceeding abroad, mainly to South Africa, 30,014 individuals were inoculated on board ship, and the incidence of enteric fever in connection with these will no doubt be forthcoming

in returns to be furnished after the close of the campaign." It is from these that we must next look for results which will encourage or discourage many in the future. We feel that in Professor Wright's hands the matter will neither be let fall, nor allowed to stand still, no matter what the South African reports may show. He will persevere and improve his methods if possible, and it will be, and is, the duty of each and all to encourage him in this, instead of, by carping criticism, stirring up feelings in any quarter which may cause obstacles to be placed in his way, thus retarding or stopping the methods and the means of investigation which undoubtedly have in them great possibilities.

When these South African reports come to hand no fair-minded physician must lose sight of the question of diagnosis. Without wishing to cast the shadow of a reflection on the capabilities of the little army of doctors, who had such herculean tasks thrown suddenly upon them; but remembering rather the doubts and even errors which occur in well-regulated hospitals at home, where every appliance, every convenience, every help is at hand; where time does not pluck us, distracted, from one duty to another; where human endurance is not tried almost to the breaking point; it must be allowed that at the "front" amid the turmoil of war some errors have crept into the returns, and that therefore allowance must be made for these when we are scanning and criticising the results of inoculation.

As a prophylactic measure inoculation cannot come into any very general use. It is applicable only on occasions where there is some great local epidemic, or where, as in the Army in India, experience shows that a large proportion of our younger soldiers are attacked and many lives lost, in spite of the most elaborate efforts to combat the spread of the disease by general and special sanitary measures and precautions. Or, again, where an army has to take the field in case of war, and where experience has taught, that disease, especially typhoid fever, is more effective in reducing its fighting strength and impeding its progress, than the bullets of the enemy.

As has already been pointed out, there is no more splendid field for carrying out the necessary investigations in that and many other subjects than the Army. The civilian medical world would learn much on many different subjects, of the very highest importance, by a more careful and systematic study of the excellent Reports of the Army Medical Department than that which is usually bestowed upon it.

### A NOTE ON STERILISATION OF FLEXIBLE CATHETERS BY BOILING.

By J. BEARD, F.R.C.S.E.,

Resident Assistant Medical Officer, Union Hospital, Bradford.

IN olden times metal catheters were the only kind available, and even now the silver catheter is the favourite instrument of some surgeons of eminence, and this no doubt from the fact that it can be readily sterilised by boiling.

But there are a great many surgeons who use extensively some form of flexible catheter, and in some cases a well-oiled flexible catheter or bougie is the only instrument which will pass through a stricture and into the bladder.

There are surgeons who object to using these fragile instruments on account of their liability to crack and break, and there is the objection that flexible catheters, or rather the point of the catheter, especially if it be a small one, cannot be felt as it

is passing along the urethra in the deeper part of the perineum.

But the real crux is how to efficiently sterilise the catheter without destroying it.

If one uses a strong antiseptic it very soon roughens the catheter and renders it unfit for use, and the same may be said of steam sterilisation.

Many other methods of sterilisation have been put forth from time to time, some very good and some expensive, but most of them open to the objection that they are tedious, cumbersome, or too prolonged a process for the busy practitioner.

I read in a contemporary journal, a short time ago, of an article which appeared in the *Centralbl. f. Chir.* of January 19th, by M. H. Hermon, on the sterilisation of silk catheters by means of boiling in a saturated solution of ammonium sulphate, and by which means the catheter could be efficiently sterilised without causing destruction of the catheter.

He says that a very dirty catheter can be sterilised in from three to five minutes, but he has boiled them for as long as five hours and they have still retained their polish, the only change which takes place, he says, is that the catheter is rendered softer and more elastic, and this he regards as an improvement.

Now the life of a flexible catheter under the best of circumstances is but a short one if the catheter be in constant use, it soon becomes rough or cracked and rendered unfit for use, and one is constantly meeting with cases of filthy cystitis in which it is unwise to use the catheter a second time if the only means of cleaning the catheter be doubtful in its result. Therefore the only alternative is to destroy the catheter at once, and this becomes a very expensive procedure.

Now, in face of such facts, if a means of proper sterilisation can be found, and that cheaply, it should be tried; therefore after reading of Hermon's method of boiling in ammonium sulphate I gave it a good trial.

I applied the test to silk-web, elastic gum, and the black olivary French catheter or catheter-a-boulé, and I found that they all stood the boiling well, but are somewhat softer after long boiling than before.

I have boiled a lot of catheters of all three sorts together every day for three weeks, giving them from two hours up to five hours at one boiling, and they seem little worse than when I put them in the first day.

I proceed as follows:—

I wash them through and through with plain warm water till it flows through the catheter perfectly clear. I then wrap them all up together in a piece of plain gauze, and put them into an ordinary steriliser containing sufficient of a saturated solution of ammonium sulphate to well cover them, and allow them to boil. After boiling I allow the fluid to drain out of them by tilting the dish which I put them on. It is as well when they are dry if they are not to be used for a while, to draw them through a sterile piece of gauze, upon which are sprinkled a few drops of pure olive oil, or they can be taken straight from the steriliser and be used, as the ammonium sulphate has no irritating effect upon the urethral mucous membrane.

#### The Mortality in Foreign Cities.

THE following are the latest official returns, and represent the last weekly death-rate per 1,000 of several of the populations:—Calcutta 24, Bombay 62, Madras 119, Paris 15, Brussels 12, Amsterdam 13, Copenhagen 20, Stockholm 14, Christiania 11, St. Petersburg 23, Moscow 30, Berlin 18, Hamburg 13, Breslau 22, Munich 20, Vienna 17, Prague 18, Buda-Pesth 17, Trieste 21, Rome 16, Venice 17, Cairo 45, Alexandria 40, New York (including Brooklyn) 19, Philadelphia 16.

## A NOTE ON THE USE AND VALUE OF ANTIVENENE IN SNAKE POISONING. (a)

By ALFRED R. PARSONS, M.D., F.R.C.P.I.,

Physician to the Royal City of Dublin Hospital and to the National Hospital for Consumption, Ireland.

It is often alleged by those critics who have no sympathy with scientific or experimental methods in medicine, that while such investigations have undoubtedly thrown light on the causation of disease, they have done little or nothing to cure it. Such people contend that modern scientific medicine has destroyed our faith in the empirical therapeutics of our fathers, but it has failed to indicate a more useful or rational line of treatment of its own. Its spirit, they hold, is mainly destructive, and shows little or no sign of any constructive power.

Ignoring for the present the fact that science must be pursued for its own sake, and not in any merely utilitarian spirit, and also the enormous benefits which have accrued to humanity in the prevention of disease from a more accurate knowledge of its aetiology and mode of propagation, we hold that brilliant therapeutic results have directly arisen from scientific investigation. In support of this contention we may refer to the antirabic injections, introduced by Pasteur, which have robbed hydrophobia of its terrors, or to the conversion of a heavy stupid cretin, into an intelligent, rational creature by thyroid feeding. Again, less than ten years ago we had to contend with a mortality of 40 per cent. in diphtheria, now by the injection of antidiphtheritic serum on the first day of the illness the mortality has been reduced to about 5 per cent. Within the last few years serums have been prepared which have been used, apparently with marked benefit, in the treatment of puerperal fever and tetanus.

Working on somewhat similar lines Professor Fraser, in Scotland, and Dr. Calmette, in France, have endeavoured to prepare a serum for use in cases of snake poisoning. We have before us an account of a visit to the Pasteur Institutes at Lille and Paris, undertaken by Staff-Surgeon Octavius W. Andrews, M.B., B.N. It contains an interesting description of the preparation of antivenene, and from it we gather the following details. The first step in the process consists in obtaining a supply of venom. For this purpose a large number of the most deadly snakes are kept at the Pasteur Institute in a glass house heated to about 27° C. Immediately before feeding, the animal is removed from its cage by seizing it just below the head with a catch forceps about two feet long. The head is now firmly grasped by the left hand of the operator, and the forceps removed. The right hand is now free to clean the fangs and to facilitate the flow of poison into a watch glass, which the assistant holds underneath them. When the venom has ceased to flow a glass funnel is inserted into the snake's mouth, an egg broken into it and forced down the animal's throat. The venom is collected in this way from three or four different species and thoroughly mixed together. It is then dried, and a 1 per cent. solution in distilled water made from it. This solution is heated to 72° C. for the purpose of coagulating the albumen, which falls down as a flocculent white precipitate and is removed by filtering through a Swedish filter paper. The filtrate is collected in sterile flasks and is now ready for inoculation. For this purpose a horse which has failed to react to the mallein test for glanders is selected, and is injected with a quantity of the solution corresponding to 1 mgrm. of venom. An abscess forms at the seat of inoculation. It is subsequently opened and dressed, and fifteen days after the first inoculation, if the abscess has healed, 2 mgrs. are injected. The dose is gradually increased from time to time, so that after one year the horse can resist a dose of 0.5 grammes of venom, that is

to say, an amount which would kill twenty-five fresh horses. If the injections be still further pressed, at the end of three years his resistance is doubled, for he can stand an amount of venom sufficient to kill fifty horses. However, when a horse can resist 0.5 grammes of venom injected subcutaneously he is in a fit state to be bled. This is done by inserting a trochar and cannula into the jugular vein under strict aseptic precautions. The blood is collected in sterile glass vessels, and after coagulation is complete the serum is syphoned off into small bottles. These, when filled, are sterilised by heating them for an hour on three successive days to a temperature of 60° C. The antitoxic value of the serum having been determined, the bottles are covered with rubber caps, coated with paraffin wax, dated, and sealed, and are then ready for dispatch to any part of the world.

It is easy to demonstrate on the lower animals, if they are inoculated with a dose of venom, the curative and protective properties of antivenene, and M. Guérin, assistant to M. Calmette, is himself a good illustration of its curative value in the human subject. This gentleman was bitten in the thumb of the left hand by a venomous snake. Five minutes later 10 c.c. of antivenene were injected into the subcutaneous tissue of the forearm. For one hour after the bite M. Guérin felt very ill, but subsequently had absolutely no discomfort.

The *modus operandi* of antivenene is not very clear. That it is not a mere chemical neutralisation is proved by the fact that if venom and a small quantity of antivenene be mixed *in vitro* the toxicity of the venom is not materially diminished, though the same quantity of antivenene, if administered before the venom, is protective. M. Calmette, influenced, doubtless, by the teaching of the French school, explains the beneficial action of antivenene by attributing to it the power of stimulating the white blood corpuscles to carry on a process of cellular digestion; for M. Calmette holds that the destruction of the venom occurs only within the leucocytes, and if these be sufficiently stimulated by the antivenene the animal will recover.

In all cases of urgency the antivenene should be injected intravenously, as by doing so it manifests its antitoxic properties two or three hours sooner than if injected subcutaneously.

M. Calmette recommends washing the wound with a 1 per cent. solution of chloride of gold, or a one in sixty solution of hypochlorite of calcium, having first applied a ligature above the seat of the wound, but he deprecates the use of the actual cautery or chemical caustics. He objects also to the administration of alcohol or ammonia, but recommends tea or coffee, and simple measures for promoting the action of the skin.

## INDIVIDUALISM IN MEDICINE. (a)

By SIR THOMAS BARLOW, M.D., F.R.C.S.,

Physician to University College Hospital, London, &c., &c.

STUDENTS, he remarked, should be impressed with the necessity of being able to concentrate their whole heart and soul on the subject in hand, and also with the great importance of self-reliance. In their professional life it would be their own personal power of observation, their own personal experiences, and the reasoned conclusions which they had drawn from them, their own personal skill, whether of handicraft or of that wider capacity of the adaptation of suitable means to definite ends, which would be called into hourly requisition. In a great many of their problems they would be able to rely on their lessons and on knowledge derived from books, but it was personality which counted. It was the power of converting their own observations and deductions upon the actual case before them into a definite theory as to its nature, and as to the proper method of dealing with it, that constituted the solid foundation of their future work. He granted that the preparation for their examinations was the first and foremost duty,

(a) A critique on an article by Staff-Surgeon Andrews, M.B., B.N., in the Report of the Naval Medical Department for the year 1893-90.

(a) Abstract of Introductory Address delivered at the Opening of the Sheffield Medical School, October 1st.

and strongly urged them never to miss a lecture or a demonstration, and to always remember that the definitely prescribed practical work was the most vital of all. "But I hope to show," observed the lecturer, "that in everyone of these exercises individualism can play its part. Now there is a type of student who suggests the old nursery admonition: "Shut your eyes, open your mouth, and see what I will put into it." He is like a prize fowl reared by the modern methods of forced feeding, stuffed with food specially prepared for him, and in a given time fattened up for the examination market and almost bursting with cram-knowledge. He is a deadly dull creature, both to himself and other people, and if he doesn't alter his ways he makes a very poor doctor. But if you are to shun the ways of the very poor smug, who, as I once heard Professor Huxley say, swallows his teacher's brains and then simply spits them up again, how can you bring in the role of individualism into your very definite and prescribed curriculum?"

Limiting his remarks to the study of anatomy, physiology, and materia medica, the speaker gave much advice as to the methods for impressing knowledge upon the mind. In anatomy, let them make diagrams of their own dissections, and keep a journal of what they had dissected each day. In physiology, let them seize every opportunity of making such experiments as were practicable, and of carefully noting the details, remembering that this was the subject which brought into play the reasoning faculty more than any other of their early studies. He urged them not to be content with empirical facts, but to try to get hold of the deductions which were to be drawn from the facts. The basis of physiology was applied chemistry and physics. Some of this was doubtful, but a great deal of it was clear enough and ought to be mastered. The individualist differed from the smug in that he was determined to know what lay behind the facts, and what the facts led to, whilst the smug simply accepted them as empirical statements to be swallowed. In materia medica he advised them to practically acquaint themselves with the various drugs with which they had to deal. There was nothing like *visa voce* examinations for improving their readiness and accuracy of recollection for the cultivation of clear, forcible utterance, and for getting rid of that wretched self-consciousness which in all its protean forms was intolerable in a doctor. Considering the work of the young medical men in a hospital, the lecturer gave a number of hints as to systematically recording what they learned from particular cases, and as to acquiring the power of rapid diagnosis in the out-patient department. Whatever else they did, they must never miss a post-mortem examination. When once they had said good-bye to the hospital they would probably have few chances of verifying or correcting their diagnosis in fatal cases.

"It is not merely," he added, "for the satisfaction of scientific curiosity that you should attend post-mortems, nor for the verification of physical signs, but you need to attend as many as possible for the sake of acquiring a well-ordered store of facts as to the average diseases which are most likely to occur in everyday experience. The post-mortem room is like a sheet anchor to the good ship clinical medicine, which moors her safely amidst the cross-currents of wild unverifiable hypothesis and transcendental speculation. To an earnest student one of the early results of the study of morbid anatomy is a state of scepticism as to any good that therapeutics can do, and for a time he may become a nihilist in treatment. But it is a wholesome scepticism, for it makes us realise what are our limitations, and how very narrow is the fringe within which it is possible for us to modify vital processes. And, paradoxical as it may sound, the post-mortem room often reveals to us, even in the hour of defeat, what a long and valiant fight the human organism has made against its foes. To choose a familiar instance, the revelation of the existence of old tuberculous deposit in such a large proportion of people dying from various diseases, so far from making us hopeless, suggests to us the great power of repair in the human subject from localised lesions of this kind.

He expressed his satisfaction at the fact that the

College was so excellently equipped with the Favell laboratory, and with a complete pathological and bacteriological department. Let them be proud of their native town and county. Those shallow folks who were pleased to sneer at provincialism little realised how much keenness, concentration, solidarity, and true citizenship existed in the great provincial centres, especially those of the North of England. They were fortunate in the organic union of the three departments of that College, and in the hearty co-operation of the different hospitals with the medical department. In conclusion, Sir Thomas remarked that in no calling was there a greater likelihood of a fair competency as the result of steady, continuous work than in the doctors'; moreover, the doctor's life, though arduous, was full to the brim of every kind of social and scientific interest.

## MEDICAL STUDENTS AND THEIR DUTIES. (a)

By THOMAS H. KELLOCK, M.D., F.R.C.S.,  
Assistant Surgeon to Middlesex Hospital.

In welcoming the new students, the opinion was expressed that rarely of recent years has the prospect in the medical profession been brighter than at the present time. Various causes, among them the addition of a year to the length of the curriculum, the substitution of qualified for unqualified assistants, the war in South Africa, the widening fields in the Colonies, and the prospect of better conditions in the Army had all their share in considerably increasing the value of the services of a well-qualified man.

The advantages to the average man of an education at one of the smaller schools were mentioned, chief among them being the comparative ease of obtaining the resident appointments and the great value and recommendation of these in later life.

The main part of the address was devoted to a consideration of the relations between students and the hospitals during the time of their pupilage and afterwards. Passing over briefly the time a student passed in the school before commencing practical work in the wards and out-patient rooms, and mentioning how important it is for a student to make the best use of that time and to learn well work that he is little likely to go back to, and of his getting into a good habit of work, it was mentioned that in the future it is possible that the time when a student begins his practical work may mean for all what it now means for those who come from the Universities, a first introduction to the hospital at all. It is easy to forget what past and present students owe to the hospitals, the enormous sums of money contributed to them have enabled them, by years of useful work, to build up such a reputation that they have become the resort of the poor directly accident or disease come upon them, and they can thus place at the disposal of the student a large mass of clinical material, and under the best conditions for studying it, one of these being the fact that in a hospital a patient consents to and expects a proper examination. The hospitals, too, provide the funds for acquiring the new and expensive apparatus that the progressive medicine and surgery of to-day render necessary, and the students get the advantages of this as well as the patients.

What a student could do for the hospital in return was considered. By carefully performing his duties when acting as clerk or dresser he could not only help himself in acquiring knowledge, but also help in the work of the hospital; it is one important duty of students at all times to be careful of their behaviour and conversation to and in front of the patients, in the wards, out-patient and casualty departments, hospital patients and their friends are not only observant, but have a propensity for discussion among themselves, and the welfare of an institution gains or suffers very much by the behaviour not only of those who have actually to deal with the patients, but of all those who

(a) Abstract of Introductory Address delivered at the Middlesex Hospital Medical School on October 2nd, 1901.



are present, even if they be only onlookers. To learn how to deal with patients is a not unimportant part of a medical education, and very often a man's success, or the reverse, when he goes into practice, depends as much on this as on his professional knowledge. At the start men generally have to deal with patients of a class differing little, if at all, from those he has seen at the hospital; it is most important, too, that he should have at least some experience in the management of children and of the parents who bring them. All of these he can learn at the hospital, and in learning to do it properly he can be of use to the institution.

The duty of students to their hospital when outside its walls is obvious. Generations of self-respecting and hard-working men have long since dispelled the idea that medical students are necessarily ill-behaved or rowdy, and those of to-day know very well that by their behaviour and conversation they can bring credit or the reverse on an institution to which they owe so much.

When a man has become qualified and leaves the hospital to start on the real work of his life, there may still be a bond of union between them, closer than that which connects him to his school or university—he has probably done with the latter altogether, but at the hospital there is always work going on that is of use and interest to a medical man, and if he wants to spend a few days or weeks brushing up his knowledge there is one place above all others to which he should go, and that is his old hospital. Students should always make welcome in all departments of the hospital those who have preceded them, and who have an equal right with themselves to what is to be learned there. A fact that is not without its lesson is that qualified men are often more interested than the student in the treatment of patients, knowing by experience how important this is and the rapidity with which they can get their patients well in practice. A correct diagnosis is the real scientific foundation, but will not in itself cure the patient, although it is everything in directing the medical man to what is the correct treatment.

There must be something very wrong with a hospital, its staff, or the medical man himself, if he cannot find enough, and more than enough, there to satisfy him when he pays it a visit, and to prevent his having recourse to post-graduate courses and such like, at any rate for ordinary medicine and surgery.

A very important feature in the relations between medical men and the hospitals is the practice of their patients resorting there for advice and treatment; statistics show what a large portion of the population go to the hospitals at some time or another, and the question as to how many of them are depriving medical men of their fees by so doing is a difficult one to decide; the majority of the out-patients, for example, appear fairly well-to-do, decently dressed, and sufficiently fed; the very poor and the partially starved are decidedly in the minority. Is this because the population, on the whole, is well-to-do, or is it also because the very poor cannot afford to live and be out-patients, but have to go to the infirmaries if they cannot be admitted to the hospitals? The opinion was expressed that the patients, as a rule, made no pretence to be worse off than they really are, and that instances of their dressing in shabby clothes to obtain admission are very rare. The causes that bring such people to the hospital were considered, it can hardly be that they save money by coming, for often their travelling expenses, to say nothing of their time, must be more than a visit to a doctor would cost them, one of these causes is the great confidence the public have in the hospitals and in the potency of the medicines given them there, they think their ailment is sure to be recognised and the right medicine given them. Many medical men have not acquired the art of gaining their patients' full confidence, and they come to the hospitals only to see if there is anything more than they have been told the matter with them. Often, too, patients will submit at a hospital to a more thorough examination than they have allowed their medical man; in this respect at a hospital we have an advantage, and are sometimes able to discover the cause of an illness, the symptoms of which have for a considerable time resisted treatment. The ways in which

medical men and the hospitals can be of mutual assistance were considered, and if at times the relations between them are strained on account of the abuse of the latter by patients it must be remembered that there are three factors concerned, the hospital, the medical man and the patient, and often the tendency of each of them is to blame the others rather than to try and remedy the part of the fault which is its own.

It is the duty of the authorities at the hospitals to keep a very watchful eye on their wards, out-patient and special departments, and prevent the admission to them of unsuitable patients; it is quite possible to decline to treat them in such a way as to leave undisturbed the relations between them and their medical man, especially as they very often apply to the hospitals under quite a misapprehension as to the objects of these institutions.

By working together the hospitals and general practitioners can, and probably do, educate their patients and the public generally in such a way as to keep this abuse of the hospitals within very fair limits.

## LIFE AND CHARACTER. (a)

By PROF. J. W. TAYLOR, M.D., M.Sc., F.R.C.S.

PROFESSOR TAYLOR compared life to a journey—"The road winds uphill all the way. Yes, to the very end"—passing on to consider life as a fortune, one which may be squandered or spent wisely, and to life as a business, adopting De Tocqueville's definition, "Life is not a pleasure or a sorrow, but a grave business which has been entrusted to our charge, and which we have to carry through to an honourable end.

The Introductory, he observed, would mark to many of his hearers the acceptance of a special career or destiny, the entry on a life work. The manner of following that career would probably be of far greater importance than the making of the choice. In dealing with this point he said: "It will hereafter be of comparatively little importance whether you are a soldier or a sailor, a clergyman, or doctor, or lawyer, but it will matter very much whether you acted as became a man called to the duties and responsibilities of the life you have chosen." Prof. Taylor then spoke of the necessary requirements for successful service, a healthy and well-trained body, a well-educated mind, and a high moral purpose being regarded as essential. Looking back on his own experience of life, he passed these under review, considered their relative value, and the instances he could recall of gain or loss resulting from their presence or their absence. Under the head of bodily health he considered, first, lives in which this had contributed very largely to success, and, afterwards, lives which had been ruined by the want of it, especially dwelling on those which by the incurrence of syphilis and alcoholism had come utterly to grief.

Under the head of mental acquirements he considered both the studies involved in medical training and the different types or orders of mind engaged as students in the pursuit of knowledge, reviewing the careers of some who had done well, and of others who had disappointed expectations or failed of the highest in spite of high intellectual gifts.

Under the head of moral purpose or character he spoke of this as being of greatest value—of the gradual perception of its importance as life went on, and of some of the more important of those good qualities which go to form the ideal physician and surgeon, putting in the first place love of truth, then love of one's kind, and then love of service.

"But what if we know that we are wanting? Then, Prof. Taylor said, it was necessary to insist on the gospel of true education, and especially so, in these days, when so much nonsense was scattered broadcast on the subject of heredity. "There is no weakness you cannot grow out of if you set your heart upon it—no strength or goodness that you may not aspire to, and in some measure attain."

Finally turning from the influence of character on

(a) Abstract of Introductory Address delivered at Charing Cross Hospital Medical School on October 2nd, 1901.

individual life, Prof. Taylor considered the influence of character on national life. Briefly describing a recent visit to the South of France, where evidences of Roman occupation, architecture, and life are still plentiful and striking, he considered the reasons for the decline and fall of Roman power, tracing it to the decay of national character, and asked whether there might not be similar dangers in the national character of England to-day. He concluded as follows:—

"Gentlemen, we have been passing, and are still passing through a time of "sifting," as every time of war must be. Older and, as I think, purer ideals, are again coming to the front. We begin to realise that the "battle is to the strong," and that the real wealth of a nation consists not so much in her material prosperity, as in the numbers of healthy upright and manly lives who can give themselves to her service, and protect her in the hour of need. Such have not been wanting in our recent struggles, men who

"Never turned their backs but marched breast forward,

Never doubted clouds would break,  
Never dreamed, though right were worsted, wrong would triumph,

Held we fall to rise, are baffled to fight better,  
Sleep to wake."

But we want more of these, and of this faith or spirit which ensures the final victory. You who will be the doctors and advisers of the future generation, may do much by steadily honouring and upholding higher ideals of individual, family, and national life, to infuse a new and healthier spirit into the coming age. For it is in the spirit of Browning's epilogue that the hardest tasks are always accomplished, it is in this spirit that a nation may sometimes be born again.

### Clinical Records.

#### THE CASE OF THE LATE PRESIDENT MCKINLEY. (a)

Under the care of Dr. MATTHEW D. MANN.

THE President's case is a striking example of how little pain may be inflicted by bullet wounds and how little conscious of their infliction the wounded person may be. The wounds were received from a distance of less than three feet. The first penetrated the abdomen, wounding only soft tissues, and the President seems not to have felt it at all and not to have realised what had happened. In fact, the shock and pain of his wounds had thus far been so little that he had to ask those around him if he were shot. Within ten minutes after the President was shot he was in one of the ambulances provided for emergency cases, and was on his way to the Emergency Hospital on the Exposition grounds. The operating-room, about 12 by 20, though small, is reasonably well lighted and is thoroughly business-like in its air of absolute simplicity and cleanliness.

As soon as the President arrived he was put on the operating-table, but without removing the stretcher on which he had originally been carried to the ambulance. This stretcher remained under him until after the operation was completed and served for his retransfer to the ambulance when he was moved to the home of Mr. Milburn. Dr. Mann arrived at the hospital at five minutes after five. The President had been wounded at 4.7 p.m., so that practically an hour had elapsed. Examination showed that while the wound in the thoracic wall was only a superficial bruise, that in the abdomen had penetrated the abdominal cavity. The President's condition was good; there was as yet no rise of temperature, the pulse was running slightly over 100, and the patient was evidently suffering slightly from shock. There had been two or more almost fainting spells, and one-thirtieth of a grain of strychnine was given as a stimulant. A sixth of a grain of morphine was administered to quiet some restlessness due to the delay. The presence of a penetrating wound of the abdomen seemed to Dr. Mann sufficient indication for at least an exploratory laparotomy.

Nineteen minutes after his arrival, that is, at 5.24 p.m., Dr. Mann made his incision. The President had been given ether while the surgeons' personal preparations were making, and he took it very quietly and without excitement. The opening of the abdomen at once disclosed the fact that laparotomy was of vital necessity, indeed the stomach had been penetrated and some of the stomach contents were already extravasated into the abdominal cavity.

An opening was found in the anterior wall of the stomach in the neighbourhood of the greater curvature. This opening was in the upper half segment of the stomach. Its position, small size, and sharp inverted edges, and the contraction of that viscus served to keep it tightly closed. That on the posterior wall was larger and more irregular, but its edges were also inverted and the amount of leakage of gastric contents was not large.

It was about three hours before his wound was received that the President had taken his lunch, but though so long a time had elapsed the stomach was found about half full. The edges of the wound were repaired with Lembert sutures. The posterior wall of the stomach was then exposed by turning the organ upward and backward, avoiding any contact with the intestines, and a wound corresponding to that in the anterior wall was found. This was sutured as the other one. All extravasation was now at an end. No other visceral wounds could be found. There was practically no hæmorrhage. The abdomen was thoroughly flushed out with sterile normal salt solution. As the bullet had not been found during the course of the rather lengthy manipulations (the patient was under ether about an hour and a half), further search for it was deemed inexpedient. The apparent direction of this bullet was, as has been said, away from the median line. There was no danger that it had injured the body of a vertebra, as in Garfield's case, and the fact that there was no noticeable hæmorrhage seemed to indicate that it had lodged in the muscles of the back, where it might well remain without doing any harm.

The question of using the Röntgen rays to locate the bullet was raised, but it was decided that unless the ball gave rise to symptoms of irritation the use of the Röntgen rays should be postponed until the President was convalescent.

The President having complained on Tuesday of some tenderness in the neighbourhood of the wound which had not only persisted but increased, it was thought better to investigate the cause for this discomfort. A small superficial collection of pus along the edge of the wound was found to be forming. Dr. Mann called the attention of the assistant surgeons to the fact that a small portion of clothing had been carried into the abdominal wound. It did not reach the abdominal cavity, but was found near the bottom of the fatty layer of the abdominal wall. The shreds of clothing were removed as carefully as possible, but it is a well-known experience that portions of such material are liable to be left in the wound. This Dr. Mann considers to have been the origin of the superficial suppuration that was found to exist. The collection of pus was evacuated without in any way disturbing the coaptation of the wound edges, and the wound was redressed as before. As a result of the relief thus afforded the President passed a more comfortable night on Tuesday and was in excellent spirits on Wednesday, asking for the paper and wanting to talk more than the attending surgeons considered good for him. Feeding by the mouth was begun on Tuesday morning and was well borne. After Wednesday all nourishment was given in this way, and the rectal alimentation of the first few days, which was fortunately always satisfactorily retained and absorbed, was discontinued.

Matters apparently progressed satisfactorily for the next forty-eight hours, when uneasiness was excited by marked cardiac weakness, with hastened, shallow respiration. This rapidly increased in intensity, and on the 14th at 2 a.m. the President succumbed to cardiac failure.

At the autopsy both apertures were found perfectly closed by the stitches, but the tissues around each hole had become gangrenous. The bullet, after passing through the stomach, hit and tore the upper end of the

(a) Compiled from American accounts just received.

kidney, which was also gangrenous. There were no signs of peritonitis or visceral disease. The heart walls were very thin. There was no evidence of any attempt at repair anywhere.

The revelations of the autopsy on the body of President McKinley (says the *N. Y. Medical Record*) are deeply significant from many pathological and surgical points.

Taken in connection with the clinical history of the case, and the extremely optimistic views of some of the consultants, the discovery of certain of the lesions named is both a surprise and a disappointment. It is a pity indeed that such an evident failure in diagnosis should have been so conspicuously demonstrated to the general public.

The operation of suturing the stomach wounds was timely, proper, and, so far as it went, brilliant; but in the light of the autopsy, we know that the operation, carefully conducted as it was, was necessarily an incomplete one. Time was precious, and prolonged search for the ball was impossible, consequently the condition and course of the wound beyond the stomach could not be positively ascertained at the time. The surgeons satisfied themselves, therefore, that it was safe to leave this terminal wound to itself and close up the abdomen. They used their best judgment under trying conditions; but, unfortunately, that judgment was in error.

Then came the bulletins, in which it was stated at first that the stomach wounds were the only causes for anxiety, that the ball having lodged in the muscles of the back would become safely encysted, and that septic peritonitis from possible leakage of the stomach contents was the only thing to be feared. When the latter danger was over, there came the surprising intelligence that the patient would certainly recover. This in face of a continued high temperature and rapid pulse! Then it was announced that all the wounds had healed perfectly, and the only real danger was centred in a weak heart. Hardly had this bulletin been issued when it was announced that the external wound was found to be infected, necessitating the removal of some stitches. Still it was said that the distinguished patient was doing excellently well—in fact, even better than before. Next was the report of an attack of indigestion, claimed to be due to food given too soon, and last of all and without warning came the appalling accounts of his rapid collapse and surprisingly quick death.

The actual facts of the autopsy seemed to prove that the conception of the case was wrong from the beginning to the end.

Unfortunately, not one of the principal lesions gave any evidence of its existence during life. The good condition of the wound behind the stomach, of which all the surgeons were so pronouncedly confident, was an illusion and a snare. What was considered to be a most insignificant factor became the most important of all. Instead of the terminal track of the bullet being healed and the ball encysted, it was found, at the autopsy, to be gangrenous throughout.

Viewing the strictly surgical aspects of the case in the light of the autopsical demonstrations, certain points of treatment might naturally suggest themselves. Everyone knows that such an injury as existed in the President's case is almost uniformly fatal. The most favourable result that could have been expected was the healing of the wound and the possible establishment of a fistula. This would certainly be infinitely better even as a tentative measure than accidentally leaving a leaking kidney or pancreas in a closed cavity to work such mischief as was manifested in the gangrenous condition of the surrounding tissues of the case in question.

Allowing that the bullet had actually lodged in the muscles of the back, also that the missile was within easy reach, it would be following a good surgical rule to establish drainage by the most direct route posteriorly. This course, however, could not be followed, as the bullet, on account of the unfortunate conditions already noted, was not accurately located. Under the circumstances, therefore, and taking everything into consideration, it is comforting to note that all was done for the distinguished patient that was possible. In fact, as was repeatedly stated by the operator, "the case was a fatal one from the start."

## Transactions of Societies.

### OBSTETRICAL SOCIETY OF LONDON.

MEETING HELD WEDNESDAY, OCTOBER 2ND, 1901.

The President, Dr. PETER HORROCKS, in the Chair.

#### SPECIMENS.

##### LARGE FIBROMYOMA, APPARENTLY ARISING FROM THE BROAD LIGAMENT.

DR. A. L. GALABIN showed a large tumour, weighing over 20 lbs. Before operation, diagnosis was uncertain; menstruation had not been affected by the growth. At the operation the tumour appeared to lie in the meso-sigmoid, as both broad ligaments were quite free. The blood supply was derived from the mesenteric and hæmorrhoidal arteries. Dr. Galabin was, however, inclined to regard the growth as having originated in the outer part of the broad ligament, and as having spread behind instead of in front of the sigmoid. The tumour was shelled out and the edges of the cavity were sutured to the abdominal wound. The patient recovered after a tedious convalescence. The tumour showed microscopically a great preponderance of fibrous over muscular tissue.

Mr. ALBAN DORAN said that he had recently met with a case of a small fibromyoma, originating in the meso-sigmoid. It was important, inasmuch as it demonstrated that these fibromyomata might arise quite independently of the uterus. In the case of very large tumours like one that he showed at a previous meeting and like Dr. Galabin's specimen the position was not conclusive, because it might be alleged that they were originally connected with the uterus.

Dr. WILLIAM DUNCAN referred to his practice in dealing with broad ligament cysts and fibroids, which was to unite the walls of the sac and close the abdominal cavity altogether. The convalescence was more rapid when this plan was adopted.

Dr. GALABIN also showed a uterine fibromyoma with sarcomatous degeneration. Abdominal hysterectomy was performed, under the idea that it was an ordinary fibroid, but microscopical examination showed the presence of sarcomatous tissue. It was a question whether the sarcoma was a primary condition or a degeneration of a pre-existing fibroid tumour. The operation was done last March, and although the cervix was left behind, the patient had so far remained in good health.

The PRESIDENT said that he saw no reason why a sarcoma should not develop in a fibromyoma just as readily as in the uterus primarily; for uterus and fibromyoma contained precisely the same histological elements.

##### FATAL CASE OF LARGE UNOPERATED OVARIAN TUMOUR COMPLICATING PREGNANCY.

Dr. HERBERT SPENCER showed this specimen. The patient had been known to have an ovarian tumour for two or three years, and when she became pregnant it had attained an enormous size. She would not consent to operation either before or after she became pregnant. She went through her labour without drawback, but three or four days afterwards the cyst ruptured and she became profoundly collapsed. She was at once transferred to University College Hospital on an ambulance, but died on arriving there. Post-mortem examination showed that the tumour could have been removed with ease either before or during pregnancy. The case formed an argument in favour of operation on all large ovarian tumours during pregnancy. Such cases had a special tendency to rupture within a few days after delivery.

##### SECONDARY HÆMORRHAGE AFTER INTRA-PERITONEAL HYSTERECTOMY.

Dr. WILLIAM DUNCAN showed a uterine fibromyoma removed by hysterectomy. The feature of interest in the case lay in the complication. He always made a special point of getting the stump free from oozing before suturing the flaps; in this case the operation was

done in the morning, and everything appeared to be satisfactory; but in the afternoon he was sent for and found that the patient was passing clots from the vagina. He packed carefully with gauze and the patient made a good recovery. He thought the case illustrated the importance of having a free passage through the cervical canal in the stump.

Dr. F. J. McCANN suggested that in a case of secondary hæmorrhage after an operation of this kind it would be good treatment to remove the stump through the vagina.

Dr. WILLIAM DUNCAN also showed a papillomatous broad ligament cyst.

Dr. H. B. ANDREWS showed (1) a fibro-sarcoma of the ovary; (2) a melanotic sarcoma of the ovary.

Dr. T. G. STEVENS remarked that the microscopical appearance of the second case was suggestive of carcinoma rather than sarcoma.

#### LEUKÆMIA AND PREGNANCY.

This paper was read by Dr. G. ERNEST HERMAN, who reported a case of pregnancy with leukæmia. He had only been able to find twelve cases hitherto published as such. Critical examination showed that in five of these the evidence of leukæmia was deficient. They had therefore only eight cases from which to draw conclusions as to the mutual influences of pregnancy and leukæmia. These eight cases agreed in the following points: 1. The presence of an enlarged spleen and liver caused patients with leukæmia to suffer more from the abdominal distension of pregnancy than healthy women. 2. The symptoms of leukæmia were aggravated during pregnancy. 3. In pregnancy with leukæmia there was a great tendency to abortion or premature labour. 4. Death sometimes quickly followed the termination of pregnancy with leukæmia. 5. If the patient survived the termination of pregnancy great improvement took place. The author concluded from these facts that in pregnancy with leukæmia the induction of premature labour or abortion was indicated as a therapeutic measure.

Dr. AMAND ROUTH said that he had tried some time ago to find some information on the combination of leukæmia with pregnancy, but with only a small measure of success. As Dr. Herman had remarked, the combination was one of a blood-dyscrasia with a condition causing pressure, by the presence of a large spleen. It was, therefore, different from ordinary blood-dyscrasias, such as hæmophilia, and also from conditions causing simple pressure, such as the presence of an ovarian tumour. He would like to ask Dr. Herman what was the effect of leukæmia on the fetus in utero. A good deal had been written on the transmission of diseases to the fetus; and it appeared that a process of filtration could be effected by healthy chorionic epithelium, whilst a diseased epithelium would allow of the transmission of disease. He agreed with Dr. Herman's conclusion that labour should be induced when symptoms began to threaten, without waiting for serious developments.

Dr. GALABIN said that he had come across one case of leucocytes with enlargement of the spleen, associated with pregnancy. It was not, however, when he first saw her a typical leukæmia, because the number of white corpuscles was not greatly in excess of the normal. He treated her with strychnine and arsenic. He saw her again when she was three months pregnant, and she then declared herself better; the spleen had diminished in size. The combination was new to him, and he expressed the opinion that pregnancy might be allowed to proceed. Soon afterwards she went abroad, and the view taken by those who saw her later was evidently that labour should be induced, but she died undelivered, apparently from hæmorrhage, after the induction had been commenced.

The PRESIDENT remarked that the condition was so rare that probably most of them had had no experience of it. He was struck by the very slight amount of hæmorrhage in the cases recorded in the paper, for they were taught that leukæmia was specially associated with hæmorrhage. Perhaps in some of the cases where death followed delivery, in which the cause of death was not stated, it may have been due to intern orrhrage.

Similarly the tendency to abortion in these cases might be due to hæmorrhage into the membranes. If this happened some time before the expulsion of the fetus there might be time for coagulation to take place, so that there was not much hæmorrhage at the time of delivery.

Dr. HERMAN, in reply to Dr. Horrocks' question, said that in one of the cases recorded the condition of the fetus was noted, and it was found to be perfectly healthy. With reference to the President's remarks, he did not think that hæmorrhage was a common feature of these cases; for the patients did not menstruate profusely, and they did not suffer from post-partum hæmorrhage.

## Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, October 5th, 1901.

THE *Obl. f. Gynæk.*, 26/1901, has an article on

#### THE TREATMENT OF PRURITUS VULVÆ,

by Dr. L. Sieburg. The anæsthesia produced by infiltration and the observation that after extensive injection of physiological solution the skin over the site of the injection remains without sensation, or at least with its sensibility much reduced, led the author to try the method in the treatment of pruritus of the vulva, perinæum, and region of the anus. His point of view is that pruritus is a secondary disease kept up by constant scratching and rubbing. The urine is first examined to ascertain whether it contains sugar. In general he regulates the diet and forbids alcohol and spices. He recommends daily exercise and enough of it to induce a sense of fatigue and need for sleep. Patients should avoid too much rest and being alone, so that they may not be able to scratch at pleasure, and short nails are recommended. Morning and evening the patient should wash for about five minutes with soap and cold water, and through the day after every evacuation of the bladder. Carbolic washing is useful. An ointment is also recommended composed as follows: cocaine 2.0, orthoform 1.5, menthol 0.5, acid carbol. 1.0, vaseline 20.0, and to be used whether there is abrasion of the mucous surface or skin or not. Patients should always have their ointment at hand, so that they may never be without the means of relief, and be therefore driven to relief by scratching. The fissures are best treated by painting with a 10 per cent. solution of silver nitrate, after which they heal rapidly. In the evening a strip of gauze, spread with the above-named ointment, is placed over the affected parts, and over this a thick pad of wadding, and kept in position by a T-bandage firmly put on. The pressure gives relief, and the patient cannot well get under the parts to scratch. If the disease has become chronic, and the skin is intact, he uses the following mixture: spir. rusci 50.0, acid salicyl. 0.5, resorcin 1.0, painted on after the usual washings. As the mixture burns and smarts, it is well to paint on a little cocaine before applying it. It has a lasting, and therefore curative, effect. Along with the above the author has also used subcutaneous injections, first of all with weak solutions of cocaine and carbolic acid; since then he has learned that the effect is due not so much to any particular drug as to the quantity of fluid injected, and he now injects up to a third of a litre of physiological solution. He uses for the purpose a hollow needle and irrigator, and injects in

various spots until there is a considerable elevation of the skin.

#### THE HYGIENIC OBJECTION TO EXCESS OF SMOKE.

Prof. Rubner has an article on the subject in the *Vierteljahrsh. f. gerichll. med.*, 21/2. The professor says that the undoubtedly injurious effects of excessive quantities of smoke in the atmosphere are due to the various properties of the smoke. It is quite a mistake to imagine that the bad effects are due to the quantity of coal dust or soot in the smoke. From careful investigation it has been shown that the deposited mass consists only partly in carbon. A great many other substances are present, such as carbo-hydrates, products of combustion such as pyridine bases, phenol, but especially acids. In the deposits of soot 9 per cent. of sulphuric acid and 7 per cent. of hydrochloric acid have been found. The gases that escape from the chimney free from smoke contain the last-named acids. But the acids which would generally escape into the air condense on the particles of soot, and as these fall they are brought into the stratum of air that serves for respiration. The action of the soot is not limited to the region through which thick masses of smoke are seen to be driving, but particles, mostly invisible to the naked eye, are pouring down from it. In addition to the above there are a number of tar products. With good stoking most of these products are completely consumed. The products of combustion and the tar products in conjunction with the acids are the substances that have the most injurious effect on the respiratory passages. These strongly smoky atmospheres may set up catarrhs and prevent or delay convalescence from such complaints.

The smoke penetrates through closed windows and doors, and its bad effects are not confined to those out of doors. Imperfect combustion leads to the formation of carbonic oxide, and this was shown to be present in an atmosphere heavily charged with smoke. The development of smoke in towns is undoubtedly the cause of town fogs, which have different characteristics from country fogs. The town fog is injurious for all plants; the country fog is harmless and easily dispersed. Town fogs in the large cities are increasing in proportion to the increased consumption of coal. When a fog comes on there is a concentration of all the harmful substances. The town fog, whether lying high or low, does this harm, also that in the winter months especially as it shuts us off from the sunshine, which is an important health-giving element.

#### SEPTIC ENDOCARDITIS.

Prof. Lenhartz, Hamburg, believes in a chronic septic endocarditis which has nothing to do with rheumatism, but is caused by the known excitors of septic disease. The diagnosis can be determined with some certainty when a murmur is heard. If fever is present along with a murmur, and it is known that no murmur was present before the illness, and if along with these there is enlargement of the spleen, there is a probability that valvular disease of a septic origin is present. The prognosis is grave, and most cases end fatally.

Treatment, according to the professor, affords no prospect. There is no specific for the various microbes. Marmock's serum in all cases in which the disease was proved to be due to streptococcus, left him completely in the lurch, and even appeared to do harm. As long as no specific is known the case must be treated

symptomatically, and everything must be done to keep up the strength and invigorate the heart. From internal remedies such as phenacetine, salicyl, and antipyrine, quinine, no good result was obtainable.

## Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, October 5th, 1901.

#### PUBLIC ANALYSIS.

TILL a very recent date the town of Cracow was without a public analyst, which was looked upon as a danger to its milk supply. Strange to say, last year's report gives 84 (2.9 per cent.) cases of milk examinations out of a total of 2,841 with nothing to be found wrong. Of the total number examined, 1,018 cases (36 per cent.) had nothing to find fault with. The milk taken at the farms was not found to be any better than that in the milkshops; 35.4 per cent. of the whole was butter, but nothing abnormal was discovered; margarine was forty-nine times examined, but nothing found wrong.

At the Cracow medical meeting Bujivid gave the members a concise report of many experiments he had carried out in the laboratory with the object of convincing himself whether tuberculosis was transmitted from the cow to man or whether it was not. His experiments, he said, were no new matter to them, as he had often on previous occasions repeated them, owing, no doubt, to the length of time experiments for a genuine test for milk had been going on. Our mycology demands proof in other animals. Now the frequency with which these animals have been operated on with abortive results lead first to a considerable amount of scepticism as to the microbe being tuberculous at all. He said that he had injected thirty animals with tuberculous milk, and had only succeeded twice in producing tuberculosis.

Again, if it be conceded that 50 per cent. of the cows are tuberculous as diagnosed by tuberculin, the percentage of animals affected after injection would be very small indeed without further testimony. After six years' experiments he was not confident that tuberculosis was induced by milk, neither would he assure the meeting that it could not be

#### TYPHUS EXANTHEMATICUS.

Typhus in Austria has been on the increase, but this must be taken relatively, as Galicia still claims a large number of victims. In 1899 there were 6,055 deaths recorded for the Empire, of which 5,941 were for the province of Galicia alone. In the same year there were 3,966 cases of small-pox in Galicia, while only 127 cases were reported from the remainder of the monarchy; thus the proportion would stand as 8,623 to 51; in 1895 the proportion was as 6,291 to 67, showing that the other provinces are improving.

Cancer is also very prevalent in this province, as the report of 1900 gives 1,487 deaths, or 2.4 per 1000. In previous years these numbers appear to be still greater, as 1891 gives 1,516 deaths; 1892, 1,479; in 1893, 1,625, or something about 2.4 per 1000.

#### PASTEUR INSTITUTION.

Following a petition to the provincial committee the Government have ordered the erection of a Pasteur Institute for the reception and treatment, according to Pasteur's method, of all rabies cases under the direction of Professor Bujivid, of Cracow.

This is the outcome of a discussion that arose during the sitting of the Polish Congress this year, when it was asked why patients suffering from rabies had to be taken to Vienna, Berlin, or Paris? Could the Government not provide for the treatment in the province?

#### LIGATURE OF SPLEEN.

Balacesen has just recorded his experiments on the vessels leading to the spleen of animals. In all cases when the ligature was applied to the gastro-duodenal artery gangrene of the spleen was the result, with subsequent death in most of the cases. In those that did recover the toxic effects were very great, while the spleen rapidly atrophied in a few days. If only one artery or one vein were cut off the organ made strenuous endeavours to establish a collateral supply by sending out connections to the abdominal walls in the form of adhesions, and thus minimising the atrophic process.

#### FERMENTATIVE INTESTINAL DYSPEPSIA.

Strassburger at the last Congress drew attention to a form of dyspepsia very intractable to the ordinary treatment, which he has taken the liberty of designating fermentative dyspepsia.

For many years past he has practised the analysis of the fæces. With a light, easily assimilated diet there should be no trace of fermentation. When fermentation is present the nutritive value is greatly reduced. This is still more emphasised if the carbohydrates pass unchanged, as it indicates an insufficient change in the alimentary canal. This fermenting power of the fæces with pain about the umbilicus is a diagnostic sign of the malady.

Ewald thought that very unsatisfactory results would be obtained from this test even on the same patient. With the microscope the unchanged starch granules could be found which would be more important than fermentation. In addition to this a large quantity of muscular fibres would be present to confirm the diagnosis.

Rosenheim acknowledged the scientific worth of Sohmidt and Strassburger's test, but feared their practical value was remote.

In the tables given for our guidance the difference was too minute to indicate pathological changes. Again, the test diet proposed is not sufficient, as many patients digest milk badly in health, which would lead to error in disease.

## The Operating Theatres.

### GUY'S HOSPITAL.

OPERATION FOR FRACTURE AND DISLOCATION OF THE HUMERUS.—The patient operated on by Mr. ARBUTHNOT LANE had sustained a fracture through the upper limit of the shaft of the humerus accompanied by a dislocation of the head of the bone forwards out of the glenoid cavity. The woman was seen by two medical men who diagnosed the condition, and did the best possible under the circumstances. She came under Mr. Lane's care some months after with a very limited range of movement of the arm, and complaining greatly of the pressure exerted by the displaced head on the axillary vessels and nerves. A radiograph showed that the fracture was as diagnosed originally, and that the upper fragment had united at a somewhat abnormal angle. The greater part of the deltoid was turned down, and the glenoid cavity was defined after

the fibrous tissue which occupied the space had been removed. The upper end of the humerus was freed from the parts which surrounded it and placed in the glenoid cavity in a satisfactory working relationship to the shoulder girdle, where it was retained by sutures.

Three weeks have now elapsed since the operation, and the patient has already got a fair amount of movement in the part.

### CHELSEA HOSPITAL FOR WOMEN.

OVARIOTOMY FOR MULTILOCULAR CYSTOMA.—Dr. ARTHUR GILES operated on a woman, æt. 48, who presented the following history:—She had been married twenty-one years and had not been pregnant; the menopause occurred at the age of forty-five and a half. Eleven months before admission she noticed she was getting stout; she began to suffer from epigastric discomfort and imagined herself pregnant, especially as she had morning sickness for some months. She supposed that the quickening occurred five months later, and made all the usual preparations for her confinement. When the time for delivery came and labour did not ensue she sent for her doctor, who expressed a doubt as to the existence of pregnancy, suggesting that the distension was due to a tumour. On examination the abdomen was found entirely distended by a cystic swelling, which bulged out considerably at the flanks, and was dull on percussion all over. Vaginal examination showed that the uterus was small and pushed back by a swelling in front of it. The cervix was of normal consistence and small. The diagnosis was that of a multilocular ovarian cyst. Operation was advised and carried out. On opening the abdomen the cyst proved to be multilocular. The contents of the loculi varied considerably, being dark and viscid in some, light and limpid in others; the total contents measured about twelve pints. There were no adhesions and the pedicle was secured in the usual way, namely, by transfixion and ligature with silk. The abdominal wound was closed in three layers. Dr. Giles said that the history of the case was interesting because whilst a spurious pregnancy with phantom tumour was not very rare at or near the menopause it was very unusual for an ovarian cyst to simulate pregnancy three years after the menopause. The supposition of pregnancy rested upon the patient's own analysis of her sensations, coupled with the abdominal enlargement and the occurrence of morning sickness; *a priori* pregnancy was unlikely, inasmuch as the patient had been sterile during twenty-one years of married life, and had passed the climacteric by nearly three years. This spurious pregnancy, he pointed out, differed from that associated with phantom tumour in that there was no mimic labour such as might occur in the latter condition. On making an examination the physical signs rendered the diagnosis easy; it was, however, instructive to remember that a doubt might arise as to whether a woman of forty-eight was pregnant or had a tumour; but in the case of many unmarried women the conditions were more easily mistaken for one another, whilst a true diagnosis would necessarily be of paramount importance to the patient, as her reputation as well as her health would be concerned. A patient with a tumour would not try to deceive her medical attendant into the belief that she was pregnant, though the converse

might happen. From these dicta Dr. Giles remarked that it was clear that the examination of physical signs was of the greatest importance, whilst the symptoms as related by a patient were of comparatively subsidiary value.

Three weeks after operation the patient had left the hospital after making an excellent recovery.

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“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, OCTOBER 9, 1901.

**THE REFORM OF THE ARMY MEDICAL SERVICE.**

THE ornate and comprehensive report of the Committee has now been published, and it affords evidence of a sincere desire on the part of those who were entrusted with the task to obviate the shortcomings which have virtually brought this branch of the Service into a state of bankruptcy and to reorganise the Service on a footing which, it may be hoped, will prove acceptable to medical men of a stamp likely to do honour to the army of which they form so essential a part. In discussing the scheme, for it must be borne in mind that it is only a scheme, that is to say, a series of mere recommendations, we are confronted with the drawback that we have no guarantee that it represents even approximately the schedule of conditions to be ultimately offered. The lay press has welcomed the report with a chorus of praise, and affects to believe that the “concessions” are as handsome as could possibly be wished. So they may be, but a lay opinion is here without much weight. Experience alone will show whether the conditions of service have been framed on such lines as to commend themselves for acceptance by those whom they are designed to satisfy. One of the great aims of the Committee has been to bring the Army Medical Service into closer and more sustained relations with the profession in civil life, and therein, unquestionably, lies an element of success of considerable importance. The principle

of promotion by seniority stands self-condemned, bad anywhere, it is simply absurd when applied to men whose value depends exclusively on their technical skill. The alternative is a somewhat alarming array of examinations—a form of competition which will revolutionise the Service and cannot fail to eliminate those whose heart is not in their work. These examinations will act as a powerful stimulus to continued study, and, if properly organised, will effectually combat the intellectual lethargy which, in times gone by, fell upon members of the Service under the chilling influence of official routine. The introduction of the civil element into the proposed Advisory Board should go far to infuse a modern scientific spirit into the administration and to secure reasonable scope for energy and individuality. However admirable this part of the scheme looks on paper its success in practice must necessarily depend upon the aptitude of the men who are appointed and upon their ability to enforce their recommendations. The weak point, indeed, seems to be that the Board has only “advisory” functions, and with a headstrong Secretary of State for War its well-intentioned suggestions may prove as sterile as others have done in the past, even when endorsed by Royal Commissions. It follows that unless the Government is animated by a spirit for which nothing in the past has prepared us, the substitution of an Advisory Board or a Director-General may turn out to be merely a shuffling of the cards. Looking at the report from a broad general standpoint, we are sanguine that if carried into practice in the spirit in which it has been conceived, it bids fair to secure adequate representation of the most advanced medical and surgical thought and experience of the day, and the provisions aim at securing a periodical supply of fresh blood. As soon as the scheme is crystallised into a Royal Warrant the problem will have to be faced of placing the Army Medical Corps on a numerical basis in keeping with present and future requirements. It is indeed expressly stipulated that the Board shall prepare and submit to the Secretary of State a scheme for the expansion of the Service to meet the needs of war or serious epidemics. We cannot doubt that the conditions of service, as modified in the scheme before us, will, if adopted, attract a fair proportion of candidates, although the prospect of a long *vista* of examinations may prove distasteful to many who would otherwise be tempted to take up this branch of practice. It would, however, be unduly sanguine to expect that the traditions of unpopularity associated with the Army Medical Service will forthwith sink into oblivion. The rehabilitation of the Service will take time, and any lack of sympathy on the part of those in power will certainly jeopardise the ultimate success of the reforms. We gladly recognise the conscientious manner in which this all-important subject has been dealt with by the Committee, and we sincerely hope that their labours may prove the turning point a long chapter of mismanagement.

## RADIOGRAPHY AND THE MEDICAL PROFESSION.

THE rapid development of Röntgen ray diagnosis has placed that art upon an assured basis and raised many questions that have a direct bearing upon medical and surgical practice. Improvements in apparatus and in methods have brought every part of the body within range of the X-ray operator. Many obscure points, not only in medical but also in surgical diagnosis, may be cleared up with the aid of a Röntgen ray examination. Nor can it be doubted that in the course of time processes will be so perfected as to bring this weapon of accurate diagnosis within the reach of every branch of medical practice. As things stand at present many of the examinations can be undertaken and the result properly interpreted only by an expert radiographer. It goes without saying that the ideal operator should possess a full knowledge of the facts of anatomy, both normal and pathological. Without such training it is impossible for him intelligently to manage a case so as to bring into due prominence the points to be investigated. The distortion due to alteration of relative position of the focus tube and the parts under examination, for instance, could hardly be appreciated at their proper value by any but an anatomist who had studied the subject from the standpoint of the practical radiographer. Clearly no one else would be able to speak with authority in the witness-box either for or against the presence of such fallacies, for the whole subject would be Greek to the non-medical operator. Then, again, in the case of resulting injuries to the patient from X-ray dermatitis the responsibility of the medical man who employed an unqualified person to take the radiogram would be that of a principal. On the other hand, if he entrusted the application of the Röntgen methods to a medical *confrère* the latter would bear the responsibility, and no British jury would convict him of malpraxis if he could show he had taken reasonable precautions. Indeed, from every point of view the employment of skilled medical radiographers appears to be the right and reasonable course for the profession to pursue. So strong is the feeling upon the point in America that it has been currently reported that the Röntgen rays were not used to locate the assassin's bullet in the case of the late President McKinley because the only available operator was a layman. Whether that rumour be founded upon fact or otherwise it serves to illustrate the existence of a growing sentiment in that direction among American surgeons. If ever there were a new branch of medical diagnosis that ought to be kept in the hands of the medical profession it should surely be that of the Röntgen ray investigation. That course is indicated by the highly technical nature of the work, by common prudence in the after-protection of the practitioner, and in some cases even by mere considerations of delicacy in the handling of many kinds of injury and disease. Yet experience shows that a

vast deal of this kind of work is entrusted to instrument makers and photographers. Unfortunately, the history of medicine is full of such abandonments of legitimate claim. If we take the single instance of the electrolytic destruction of superfluous hairs. This useful little cosmetic operation has drifted almost entirely into the hands of advertising individuals who possess the medical qualification. In this way many thousands of pounds are lost annually to the medical profession, who allow the exercise of a legitimate and purely surgical procedure to pass into extra-professional quarters. The remedy is clearly to obtain a reasonable amount of protection against unqualified practice alike in the interests of the public and of the medical profession. Now that the election of Direct Representatives for the General Medical Council is about to take place it would be a good opportunity of learning the views of candidates as to the best way of dealing with unqualified competition. With the present constitution of the Council, however, it seems almost hopeless to look for any initiation of reform in that direction. The increase of Direct Representatives and reconstitution of the methods and powers of the Council lie at the root of this as of most other desirable changes in the medical world, and should claim the earnest attention of every voter in the forthcoming election.

## Notes on Current Topics.

### Smiling as a Cure for Melancholia.

A TRANSATLANTIC specialist in mental disease calls attention to the reflex effect of facial expression in mental disturbances of a melancholic type. He asserts that just as the state of mind is reflected on the features, so, conversely, the contraction of the facial muscles reacts on the mental condition. If the risorius muscles are called into action, producing the simulacrum of a smile, the trend of the thoughts is thereby changed and melancholy departs. So long as you laugh you cannot cry, such is his maxim, and he states that considerable experience has convinced him of the efficacy of this method of treatment. All that the melancholic patient has to do, when he feels "the blues" coming on, is to curl up the corners of his mouth, and forthwith his drooping spirits will revive and his humour change. He invites incredulous readers to try the experiment on themselves and impartially to note the effect. Seeing, however, that mental depression is usually due to some organic or functional disturbance, dyspepsia or impaired cerebral circulation, that is to say, cerebral anæmia, we must confess to a certain scepticism. No doubt the reflex is prompt enough in the normal, healthy subject in whom the mental condition is merely the reflection of environment or circumstances, but we doubt the efficacy of the procedure to obviate the effects of some underlying circulatory or other disturbance. It may do for a Mark Tapley to turn up the corners of his mouth with an irrepressible deter-



mination to be jolly under adverse circumstances, but it is precisely this determination to be jolly which is wanting in the individuals who suffer most from mental depression.

#### Boracic Acid as a Food Preservative.

SANITARY authorities very properly view with distrust the addition of so-called preservatives to articles of food, but considerable difference of opinion obtains as to the actual effects attending their ingestion in food. The researches recently carried out by Dr. J. Kister, of Berlin, on the physiological effects of boracic acid are therefore of interest. He found that the ingestion of between forty and fifty grains of the acid daily, by strong, healthy subjects, gave rise in from four to ten days to albuminuria, which persisted concurrently with the administration of the drug. In other experiments even fifteen grains a day sufficed to determine vomiting and diarrhoea. The administration of fifteen-grain doses in a normal subject was followed within two hours by its appearance in the urine, complete elimination taking eight days. With half that dose excretion began at once, and only lasted five days. It follows that the daily ingestion of even small doses of boracic acid is apt to give rise to cumulative effects which may ultimately determine toxic symptoms, and his experience tended to show that young persons are much more susceptible to the influence of the drug than is the case later in life. We are therefore justified in assuming that the addition of boracic acid to food is by no means as innocuous as we have been asked to believe, and the hands of sanitary authorities will be strengthened in prohibiting the use of a preservative fraught with danger to the public health.

#### Individualism in Medicine.

THE subject of Sir Thomas Barlow's address at the Sheffield School of Medicine, an abstract of which we publish elsewhere, is an eloquent appeal to students to "be not like dumb driven cattle" in the assimilation of knowledge. Knowledge, he tells us, is not merely to be acquired, but requires to be assimilated if it is to yield the results expected of it. The average student, it is to be feared, contents himself with committing to memory such information as is placed before him, without bringing his reason to bear thereon. Scientific facts are, after all, but intellectual tools, the use and application whereof must be guided by the intelligence, hence the importance of a reasoning apprehension of their scope and bearings. The man who trusts to his memory in deciding diagnosis and treatment shows himself as devoid of originality as he who relies on his memory for his jests. The student, and studentship is lifelong, should draw his own diagrams, compose his own *memoriæ technicæ*, and thoroughly masticate his learning, not merely swallowing his teacher's brains, to spit them up again at examinations. It is the individualists in medicine who are mainly instrumental in effecting

progress, and not those who promptly lapse into rule of thumb as soon as they have acquired the right to practise. A sceptical attitude is far more conducive to real knowledge than the omnivorous mind which accepts every fact placed within its reach without taking the trouble to master its associations and precise significance.

#### Pernicious Anæmia in Infancy.

PERNICIOUS anæmia is a condition very rarely met with in infancy. The diminution of red blood-corpuscles and hæmoglobin produces an anæmia extremely common in childhood. Children suffering from chronic diarrhoea, from extensive tuberculosis, or from scarlatinal nephritis, are invariably anæmic, as are also those who become atrophic in consequence of defective nutrition, and who are living in overcrowded rooms and damp cellars. But in all these cases the anæmia is of secondary importance. The form under consideration is known as pernicious anæmia, which develops in otherwise healthy children. It usually occurs between eight and ten years of age, and almost as frequently in boys as in girls. Under eight years of age it is practically unknown, though some cases of it in infancy are on record, one of the most interesting being that of Rotch, brought before the American Pediatric Society. The little patient was but nine months old, without any trace of syphilis or malaria. It was well nourished at four months of age; at nine months the symptoms developed, and a well-marked precordial soufflé was found. The treatment consisted of arsenic internally and oxygen inhalations. The age of the child makes the case interesting and worth recording; it being one of those unlikely diseases for such a young child to contract, the physician might easily be at fault in his diagnosis.

#### Psychic Troubles in Heart Disease.

SLEEPLESSNESS is the indication of a morbid condition, not necessarily involving the cerebrum. But when the condition is prolonged it may become the exciting cause of grave mental troubles. The most distressing forms of insomnia are those found in connection with heart disease. The influence of cardiac disease has long been recognised by psychologists. It is possible that Nasse (1818) over-estimated the influence of cardiac lesions, but the fact remains that Tyerman in Colney Hatch found cardiac or valvular disease in one-seventh of the female patients in the asylum. Less severe adhesions than those producing such untoward results constantly come under the notice of the practitioner, and give him grave anxiety. An attempt to classify the lesions into those that bring joyous, and those that bring depressing dreams has been attempted by Dr. Zederbaum (*N.Y. Med. Journal*). He finds that in mitral insufficiency there is mental depression, probably from venous stasis in the cerebrum. The patient is apathetic, melancholy, dissatisfied with his surroundings. In the aortic lesions the psychic troubles partake more of the maniacal

and delirious type, and in such cases the suicidal tendency is not unfrequently developed. The unfortunate part is that the condition of psychic unrest is amenable only to treatment through the cardiac therapeutics, which in advanced cases are unsatisfactory.

#### Functional Disorders of the Heart.

A GOOD example of the diversity of symptoms that dyspepsia associated with flatulence may produce is recorded by Dr. Rumpe in a recent number of *Deutsche Med. Wochenschrift*. The patient, a man of thirty years of age, had long been in ill-health. He had rapidly lost flesh and complained of palpitation when he lay on his left side, when the apex beat could be felt in the axillary space. Like many dyspeptics the patient considered he had an incurable heart disease. He, however, submitted to treatment, and in three years put on flesh, forgot he had a heart, and was able to resume his ordinary calling. On examination the heart was found to have resumed its normal position and rhythm. The explanation of the phenomena offered by the author is that a greatly distended stomach pressed up the diaphragm so much that the heart almost lay horizontally in the thorax. The wasting of the patient was solely due to the dyspepsia. It is interesting to note that not only did the man put on flesh but the stomach gradually contracted until it reached the normal size, and the heart gradually returned to its natural position. One is almost driven to suspect that there must have been abnormal mobility of the viscus for it to assume the horizontal position.

#### The Birmingham Consultative Institution.

IT is stated that this institution, which has remained in a state of suspended animation since Dr. Irvine's retirement, has now definitively "given up the ghost," the door-plates having recently been removed. It is to be hoped that we have heard the last of this ill-starred attempt to provide consultants at store prices. The scheme was pre-doomed to failure from its inception, though it made a sturdy struggle for existence. The profession, as a whole, will experience a feeling of satisfaction at the success of the opposition which carried the day by reason of the energy and united action of the practitioners of Birmingham.

#### Medical Bulletins.

IT is to be hoped that the example set by American *confrères* in furnishing the press with detailed reports of the surgical and medical aspects of the late President's operation and progress will not be accepted as a precedent. Obviously the public have a right to know what an illustrious patient is suffering from, within certain limits, and to be made *au courant* with his condition from day to day. More than this is neither desirable nor seemly. To appreciate the difference one has but to compare the laconic and guarded utterances of the medical men in attendance on her late Majesty the Queen with the voluble statements which fed the daily Press in America with material for sensa-

tional copy. The fierce light which beats upon a throne does not, or should not, penetrate the sick chamber, and the sufferer, however exalted his position, has not forfeited his right to a modicum of decorum and respect. The inopportuneness of professional garrulity was accentuated in the case of the late President by the unduly optimistic and misleading nature of the "confidences." We make these remarks in no spirit of captious criticism, nor will we presume to condemn too harshly manners which are peculiar to countries other than our own, but we should be sorry to see the example generally followed.

#### Carbolic Acid as a Dressing for Burns.

ON several occasions in the past the application of pure carbolic acid has been recommended in the treatment of burns. In view of the active escharotic properties of this substance, the idea has never appeared to commend itself for adoption, but of late its use has again been advocated by practitioners in various parts of the world. Among recent advocates of the treatment Dr. Muench, of Washington, asserts that the application of the pure acid brings about healing much more rapidly than any other method of treatment. It also presents the advantage of suppressing the pain associated with this form of traumatism, in virtue of its analgesic action. Dr. Muench states that the acid coagulates the serous exudation, forming an impermeable layer which effectually protects the injured surface from contact with the air, thus fulfilling one of the most important indications in the treatment of burns. He has employed this treatment in burns of considerable extent without ever having observed symptoms of absorption or the undue formation of cicatricial tissue. In the face of this evidence it must be conceded that the application of the pure acid is, at any rate, devoid of injurious consequences, and we commend it to the notice of our readers who have much experience of this class of injury.

#### Sudden Death from Cardiac Disease.

THE frequency with which cases of sudden death occur among French troops has, for some time past, been engaging the attention of M. Kelsch, who, in a paper read at the Academy of Medicine, divides the cardiac lesions producing this fatal result into three great groups. First, he includes cardiac hypertrophy, pure and simple, without any change of histological tissue, and free of fat accumulation. Secondly, valvular degenerations, and thirdly, aortic degenerations. These changes do not interfere with the soldier carrying out his ordinary routine duties; but when a sudden and severe muscular strain is called for the feeble aorta and heart are unequal to the task of carrying on the circulation in the presence of the greatly increased arterial tension. The heart becomes paralysed by over-distension, and the degenerated aortic walls break under the strain. It would be interesting to know what part, if any, the dress of the soldier has in the aetiology of these diseases. The discontinuance

of the picturesque cross-belts in the British infantry has almost eliminated aortic aneurism from the list of the soldier's diseases.

#### Poisonous Stockings.

IN the manufacture of silk on the Continent sufficient supervision is not exercised to prevent serious and dangerous contamination of the fabric. The grave risks incurred by this want of inspection are especially noticeable in the lighter shades of silk, particularly yellow silk, and care should be taken to avoid wearing such a material next to the skin, because it is sometimes impregnated to a very considerable extent by tin chloride, in order to increase the weight and give the article a fictitious appearance of high-class quality; technically speaking, the proceeding imparts more "body" to the fabric. The medical interest in the matter arises from the difficulty of diagnosing the condition caused by the absorption of the tin chloride. The *Wiener Klin. Rundschau* has done well in publishing the details of a case of the kind, and we consider that the subject should be pressed home to the notice of the responsible authorities. The symptoms in this instance, in a young lady who had been wearing yellow silk stockings, began with a sudden failure of motive power and of sensibility in her limbs. This disability was recovered from, to a certain extent, but when the patient began to get about again and resumed the wearing of the yellow silk stockings alarming symptoms of an ataxic character set in, and an examination of the urine revealed albumoses, serum albumin, and globulin. The urine was also observed to give the reaction for tin, and on examination the yellow silk stockings were found to be impregnated with tin chloride. It was further found that the patient exhibited considerable destruction of the corpuscular elements. Recovery in this case was slow, and for months the urine continued to give the reaction to tin. A considerable amount of time and attention has been bestowed on the adulteration of certain goods with borax and boracic acid; it would be advisable if the more dangerous trade customs were also investigated and regulated.

#### Is the "Conscientious Objector," a Fool?

THE "conscientious objector," that most curious offspring of a weak Cabinet, is a familiar object in the police-courts of the United Kingdom. Indeed, so frequent is his appearance that newspaper reporters have ceased to make any note of him, unless there be some special circumstance of interest connected with his visit. He is often soundly rated by the magistrate, but it is not easy to see why the conscientious man should be abused for taking advantage of a clause created for his behoof by the wisdom of the Legislature. Surely what is good enough for the august members of Mr. Balfour's Government should suffice to silence the rebellious sarcasm of police-court magistrates! Recently, at the Bideford County Sessions, the Chairman, Sir W. Dowell, is reported, when a gardener applied to him for a certifi-

cate of exemption, to have said, "I think you are a fool." If the applicant be a fool, what in the name of common sense, is the position of the Government that have given him a legal standing for his foolishness? It is hard to understand the position of the magistrate who addresses in that fashion an applicant coming to the court on a perfectly legitimate errand. The police magistrate is appointed to administer the law, and in spite of every sympathy with his disinclination to act as the anti-vaccinationist catspaw, we must confess that it seems to us he has no right to do more than utter the mildest of remonstrances to the "conscientious objector."

#### A Departure in Workhouse Dietary.

THE wastefulness of the ordinary workhouse diet is notorious, not only in the direction of nutriment but also of cost. The issue per head of a certain quantity of each article leads to the inevitable return of a large excess, which is not replaced by any equivalent. Apart from quantity the question of quality, so far as variety is concerned, is open to greatly needed improvement. The administrators of the Poor-law, however, are slow to act, although of late years even their conservative minds have been to some extent permeated by the humaner methods of thought that characterise modern life. In some few districts attempts are now and then happily made to introduce practical reforms into the workhouse. Thus, the guardians of the Malton Union, Yorkshire have recently approved a revised dietary, whereby seed cake is substituted for plain cake for the inmates of the house, with the option of having jam or marmalade for supper; while during the winter they are to have boiled beef instead of the ordinary cold joint. It is likely that with a little management similar changes could be made in other Poor-law institutions with little or no addition to the actual existing cost of maintenance. It has been proved over and over again that the system of rigid allowances per head of inmates is in practice costly and extravagant.

#### A Plea for the Domestic Servant.

OF all classes of unskilled labour one that calls most clearly for reform is that of the domestic servant. For many years past in the United States of America the old-fashioned, patient household drudge has disappeared for ever. Here at home, in the United Kingdom, she has for a long time been steadily decreasing in numbers, until she bids fair in time to become as rare as the white sparrow or other—*rara avis in terris*. The reason is not far to seek, that is to say, if the inquirer be a candid man, and not a prejudiced woman who can see nothing wrong in the way the average servant is treated in middle-class households with a not too liberal income. Recently the Medical Officer of Merionethshire, Dr. Jones, spoke out his mind on the subject with no uncertain voice. He pointed out that many of the servant girls in the fashionable seaside resorts worked from morning to night—the first up and the

last to rest. They slept in the basement, at the top of the house, in badly lit and badly ventilated rooms, with no fireplace, or, worse still, in the dining-room, on a sofa, after the room was clear of its occupants. He had known cases where servant girls slept on such sofas when suffering from advanced phthisis, yet they went on working, a centre of infection for others inhabiting the same house. A good deal was heard about bettering the condition and environment of shop assistants, but he asked to be allowed to plead the cause of the servant maid. Other medical officers of health would do well to follow Dr. Jones's example and devote some attention to a deserving and much neglected class of the community.

#### The Parish Vaccinator in Sweden.

At the present moment a special interest is attached to all that appertains to vaccination, so that there need be no apology for a note on some curious methods pursued in Sweden. The country in question is fairly free from small-pox, so that many medical men of the present generation have never seen a case of the disease. That immunity may be in great measure ascribed to the labours of the parish organist, who for many years has filled the post of Government vaccinator. The organist is a public official who has gained his position after a series of examinations, which cover not only his musical but also his general education. Among other things, he is required to prove his acquaintance with the principles and practice of vaccination. When appointed to a parish his duties include the registration of births and deaths, so that he is able to check the vaccination returns, and act as prosecutor should occasion require. The organist has a small farm or estate granted him, and he is often a man of considerable education and of some importance in his district. He is entitled to a small fee for vaccination, or it may be done in some cases gratuitously, but those who wish can go to qualified medical men to have the operation carried out. The origin of the custom lies clearly in the dearth of medical practitioners among the sparse population of the rural districts. Established churches, on the other hand, are distributed throughout Sweden, and the combination of the functions of organist registrar, and public vaccinator in one and the same person is no doubt a great convenience to dwellers in the country.

#### Superheated Air in Otitis Media.

CONSIDERABLE success has attended the treatment of chronic catarrhal otitis media by means of superheated air. At the outset we would especially draw attention to the fact that this therapeutical measure should not be resorted to in cases of arteriosclerosis, nor when there is serious effusion into the tympanum, nor in cases where the tympanum is perforated. One result appears to be an almost invariable accompaniment of this procedure, and that is headache, which, however, can be remedied by codeine. The method that is followed by the most marked success extends over several

months, and consists essentially in packing the cleansed ear with dry gauze, and placing also a pad of gauze outside the ear. Then hot air is sent into the canal of the ear by means of a canvas-covered sleeve. The temperature of the air should be at first quite moderate, and then gradually increased; 400° F. having been used in some cases. If arrived at by degrees; this intense heat is capable of being applied through the moisture being absorbed by the gauze packing. To secure the passage of the hot air into the ear special care should be taken to have at least one perforation in the canvas hot-air conductor close to where it touches the ear. Careful inflation of the Eustachian tube should then be carried out, and subsidiary measures generally seen to. The reason of the success of this treatment is apparently to be ascribed to the stimulation of the circulation by the intense heat which sets up an absorption of articular deposits and relieves the stiffness of the internal muscles of the ear. Certainly benefit accrues from the removal of adhesions between portions of the ossicular chain and the adjoining bony walls of the middle ear. We consider that with the limitations already detailed this therapeutical procedure should be more generally practised, and it is encouraging to note that Hopkins, whose method it is, has only had four failures out of sixty-two cases during the last four years.

#### Watercress.

THE death of a man in Poplar after eating watercress has led the local medical officer of health to issue a warning against the use of watercress grown in polluted waters. This is a danger to which we have often called attention, a danger which is presented by watercress in common with most vegetables which it is customary to eat uncooked. The ditches which furnish a large proportion of this vegetable in the market usually, if not invariably, contain more or less stagnant water contaminated with the washings of the neighbouring land, and often the receptacle of all kinds of filth. The watercress is more often than not washed in a most perfunctory way, if at all, and enters the stomach laden with nameless forms of impurity. Careful cleansing is doubtless a certain safeguard against the transmission of disease, but it is from every point of view preferable, as far as possible, only to make use of watercress of known origin.

#### The Significance of Intermittent Limping.

IT has been urged as a reproach against some English practitioners that they are too ready to ascribe pain to the influence of gout, especially in patients over the age of thirty-five, and the effect of this bias in the practice of medicine may lead to more or less serious conditions being overlooked. When a person has pain during the act of walking that is relieved by rest, but occurring again on the resumption of movement, one investigation that should at once be thought of is to inspect the condition of the arteries of the feet with a view to

determining the amount of pulsation. In the middle-aged, and those older than that, the absence more or less of pulsation is sufficient to justify the opinion that the case is not one of gout, rheumatic gout, rheumatism, neuralgia, or sciatica, but falls under the heading of the disease described by Goldfiani (*Neurol. Centralb.*, March 1st, 1901), as "intermittent limping." In 28 per cent. of the cases gangrene supervenes, and in a considerable number of others the mischief is of a progressive nature, though experience shows that in a certain proportion the disease may continue in a stationary condition for years. With careful treatment, directed to securing necessary rest and the alleviation of the symptoms, combined with good diet, much can be done, but we should advise the practitioner to give a guarded prognosis at first.

#### The Epidemic of Small-Pox.

THE total number of patients suffering from small-pox actually under treatment in the hospitals of the Metropolitan Asylums Board is about 170. The disease shows no tendency to rapid extension, though each day brings its quota of victims. In the meantime the desire on the part of the public to obtain the protection of vaccination shows no sign of diminution, and practitioners all over London are still busy in this direction. It has been decided to utilise the South Camp at Gore Farm, hitherto held in readiness for the reception of cases of plague, for the accommodation of convalescent small-pox patients, who will in future be sent there.

THE winter course of clinical demonstrations by members of the medical staff of the Central London Throat and Ear Hospital commences next Wednesday evening, the 16th inst., at eight o'clock with an introductory lecture by Mr. Lennox Browne on "The Relationship to General Medicine of the Special Diseases treated at the Hospital, also to other Diseases Constituting Separate Specialisms."

#### PERSONAL.

LIEUTENANT F. W. LAMBELLE, M.B., B.S., of the Royal Army Medical Corps, has just been appointed to the surgical command of Connaught Hospital, Aldershot.

DR. LINDSAY STEVEN, Glasgow, has been appointed examiner in medicine and clinical medicine, and Dr. Charles Workman, Glasgow, examiner in pathology in Glasgow University.

SIR WM. MCCORMAC will deliver an address on October 14th, at 5 p.m., on the occasion of the opening of the new buildings of the Post-Graduate College at the West London Hospital.

SIR MICHAEL FOSTER has been elected to the office of Honorary Perpetual President of the International Congress of Physiologists by the members of the Fifth Congress which recently met in Turin.

LORD BRASSEY will deliver an address at the Royal

United Service Institution on October 16th, at 4 p.m., on the occasion of the opening of the third winter session of the London School of Tropical Medicine.

SIR FRANCIS LOVELL, late Surgeon-General of Trinidad, has been entrusted by the London School of Tropical Medicine with a mission to tropical and other countries, for the purpose of investigating diseases peculiar to those regions.

DR. T. B. ADAM has been appointed Assistant Secretary of the British Medical Temperance Association, the large increase (over 1,000 members and student associates) involving more work than the hon. secretary, Dr. Ridge, is able to devote to it. Dr. Adam will work specially among medical students.

SIR JOSEPH DIMSDALE, the Lord Mayor-elect of the City of London, is a descendant of the famous Dr. Dimsdale who flourished in the middle of the eighteenth century, and was the author of a much-quoted work on "General and Partial Inoculation" for the prevention of small-pox. This Dr. Dimsdale it was who received a fee of £10,000 and an annuity of £500 for inoculating the Empress Catherine and her son.

PROFESSOR VIRCHOW will be presented with a costly congratulatory address on his eightieth birthday next Saturday in Berlin. Deputations from many parts of the world will be present, and the Italian deputation will be headed by Minister Baccelli, who will hand to the great pathologist a portrait of himself in a very richly decorated frame. Professor Virchow is, moreover, to be made an honorary Professor of the University of Rome, from which he will receive a gold medal.

#### Scotland.

[FROM OUR OWN CORRESPONDENT.]

#### THE CHANGE AT GARTNAVEL.

AFTER the long period of twenty-seven years Dr. Yellowlees has resigned the appointment of Physician Superintendent of this classic institution for the treatment of the insane in the West of Scotland. It is no exaggeration to say that no institution in Scotland is better known than Gartnavel for the work it has done, and for the importance of the position held by its physician superintendent. It is gratifying to think, that, though an unfortunate accident is primarily the cause of his resignation, the accident will merely incapacitate for duty, and that Dr. Yellowlees has resigned only after a lapse of many years, and when his life's work was practically done. We shall look with interest to the steps taken for the appointment of his successor, for in Gartnavel we have one of the leading institutions for the treatment of the insane in the country, an institution to which we look for light and leading, and which requires to be guided by a man of first-class ability. Names are obviously unmentionable, but the management has a free hand, and there is no scarcity of excellent candidates for the appointment in the papers. The salary is a handsome one, though considerably cut down from the previous one, to begin with; but we have no doubt that the Board will deal handsomely with a good man as it has done in the past, and that the prestige of the position will not suffer from the change that is being made. One thing that is much required, now that a change is being made, is that a superintendent will be appointed whose time will be taken up more with scientific and administrative work and less with consultations; in this respect Gartnavel has been rather behind the times.

**GLASGOW MEDICO-CHIRURGICAL SOCIETY.**—The annual general meeting of the above Society was held in the Faculty Hall, St. Vincent Street, on Friday evening, October 4th. Dr. W. G. Dun, President, delivered the presidential address "On blood-letting in the treatment of disease." It was rather historical than critical, and in it the history of blood-letting was traced down through the centuries to the present day, when it was very seldom resorted to. The address was a very instructive, and, at times, a somewhat amusing one, as when the case was mentioned of a patient who, in the course of an ordinary illness, had over 200 ounces of blood withdrawn, and one ounce and a half of tartar emetic administered, and yet recovered. Several cases were cited in which blood-letting undoubtedly contributed towards a fatal result, and cases again were mentioned where it certainly did much good. Dr. Dun concluded by saying that he believed there were cases to-day in which blood-letting might very advantageously be used. Great discrimination, of course, would require to be exercised in the selection of suitable cases for it. On the motion of Mr. H. E. Clark, seconded by Dr. Lindsay Steven, a cordial vote of thanks was awarded Dr. Dun for his interesting and exhaustive address. Office-bearers for session 1901-1902:—President, Dr. W. G. Dun; vice-presidents, Dr. J. Lindsay Steven and Mr. A. E. Maylard. Council: Section of Medicine, Dr. J. W. Allan, Dr. Carslaw, Dr. Hinshelwood, and Dr. Robert M'Kinlay; Section of Surgery, Dr. Rutherford, Dr. Edington, Dr. J. H. Nicoll, and Dr. Gibb; Section of Pathology, Dr. Teacher, Dr. Ferguson, Dr. R. M. Buchanan, and Dr. A. A. Gray; Section of Obstetrics, Dr. Gibson, Dr. Kerr, Dr. Balfour Marshall, and Dr. A. N. M'Lellan; treasurer, Dr. Barclay Ness, 19, Woodside Place; editorial secretary, Dr. Hugh M'Laren, 44, Kelvingrove Street; general secretary, Dr. W. K. Hunter, 1, Newton Terrace.

**RESIGNATION OF PROFESSOR JOHN YOUNG.**—Professor Young, who has for thirty-five years been the occupant of the chair of natural history in Glasgow University, has just tendered his resignation on account of failing health. He has asked the University Court, as a special favour, to allow him to continue to hold the office of Keeper of the Hunterian Museum.

The personnel of the Scottish National Red Cross Hospital are to be presented with war medals at a parade on the York Hill drill ground, on the 26th inst., by Lieut.-General Sir Archibald Hunter, commanding the forces in Scotland. On this occasion an ambulance display on a considerable scale will take place. Surgeon Lieut.-Colonel Beatson, V.D., will be in command.

**CARNEGIE TRUST.**—The funds of this trust are to be available for the coming winter session. Already between 4,000 and 5,000 applications have been received and are now being considered by the trustees. Applications will still be accepted till the 16th inst. from Scotch students.

**GLASGOW SOUTHERN MEDICAL SOCIETY.**—The first meeting of the session was held on Thursday evening, October 3rd, when Dr. C. E. Robertson, the Society's representative on the board of governors of the Victoria Infirmary, gave an account of his stewardship for the year. He referred in feeling terms to the loss sustained by the hospital in the deaths of Drs. James Dunlop and Adam Kelly, both of whom were governors of the hospital. In the election of a gynaecologist to the hospital where there were two candidates—a lady and gentleman—each with first-class recommendations, he supported the candidature of the gentleman, who was elected. The following office bearers were elected:—Hon. President: Thomas M'Call Anderson, M.D., F.F.P.S.; President: John Stewart, M.D.; Vice-presidents: Duncan Macgilvray, M.B., C.M., and Thomas Richmond, L.K.C.P., L.F.P.S.; Treasurer: Andrew S. Tindal, M.D.; Secretary: John Fraser Orr, M.D.; Editorial Secretary: Andrew Wauchope, M.B., C.M.; Sealkeeper: Matthew Dunning, M.B., C.M.; Extra Members of Council: John Lindsay Steven, M.D., F.F.P.S., Hugh Kelly, M.D., James Hamilton, M.B., C.M., F.F.P.S.; Court Medical: William Watson, M.D., Ebenezer Duncan, M.D., F.F.P.S., Robert Pollok, M.B., C.M., F.F.P.S., Thomas Kirkpatrick Monro, M.A.,

M.D., F.F.P.S., Alexander Napier, M.D., F.F.P.S.; Representative to Victoria Infirmary: Charles E. Robertson, M.D.

## Correspondence.

[We do not hold ourselves responsible for the opinions of our correspondents.]

### THE BIOLOGICAL TEST.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Dr. Sers invites me to reconsider my position. With your kind permission I will, in a very few words, re-state my argument which he attempts to obscure.

1. My relative was suffering from a malady which seemed to be doubtful of diagnosis.

2. To settle the question certain animals were inoculated with his sputum. They died, it was declared, of tuberculosis, and my relative, it was then decided, was suffering from that disease.

3. He was removed to the South Coast, and a physician, disputing the diagnosis, held that it was a case of chronic pneumonia, and treated him accordingly. My relative was perfectly cured in about six weeks.

These are simple facts, and I merely ask how did the biological test help in this case?

With regard to the action of corrosive or irritant poison on animals, of course a red-hot poker will burn an animal equally with a man, and so will sulphuric acid and aqua fortis equally injure both; but how about the action of opium, belladonna, strychnine, and the poisonous alkaloids?

I am, Sir, yours truly,

EDWARD BEEDOX.

London, October 4th, 1901.

### THE CONGRESS ON TUBERCULOSIS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR

SIR,—My attention has been called to a letter in your issue of the 18th ult. from an anonymous correspondent, which is written for the purpose of bringing contempt upon a proposal I have put forward in the interest of "sufferers from consumption," in the *Times* newspaper.

I have no intention of entering into a paper warfare with people who have not the courage to sign their names, but I presume such a paper as yours would hardly admit such a communication into its columns unless it was from a person of some little standing, so, as your readers might be misled by your correspondent, "Ubique," I will ask you to give insertion to these few lines, more especially as he mentions me by name.

"Ubique" somewhat rashly, as it appears to me, undertakes to speak for "every medical man of the world," and assures your readers that every one such is willing to pledge himself that "no scientific data" would (or, I presume, could) be forthcoming to establish the claims put forward for the "Lachnanthes treatment."

He gives his colleagues in the profession credit for a prejudice and narrow-mindedness which they do not deserve. What grounds he has for passing so sweeping a judgment upon them does not appear, unless it be that he judges of human nature by his own standard. I do not believe that there are many in the noble profession, for which he presumes to speak, who would express a willingness to give a "verdict" without a "trial."

"Ubique" pleads guilty to a very incomplete knowledge of the "physiology of the lungs" and of the progressive morbid phenomena following tuberculous infection! I do not pretend to any knowledge on these subjects. I endeavour to bring a little common sense to bear, and judge by results. "Ubique," it appears to me, instead of being prepared to study and work for the cure or alleviation of suffering, is satisfied to retire behind his ramparts of professional prejudice and sneer at any effort by a layman to do good. He speaks of "false hopes raised in the hearts of wretched patients!" If those hopes are not to be realised it will be through the "obstinate blindness" to the existence of remedies

which are known to be efficacious in which he and others indulge themselves—"none being so blind as those that won't see"—but of whom, I trust, there are not many in the splendid profession to which I assume he belongs.

He is kind enough to drop a sympathetic tear at the contemplation of the punishment, which, he says, is to overtake me when I realise the harm I have done! and he suggests that I would have done better to have placed myself in the hands of "advisers having a knowledge of science," under which description, I presume, he includes himself! If he does, let him state his name, show himself ready to put his hand in his pocket and exert himself to further develop his "knowledge of science," and apply it for the benefit of his suffering fellow creatures.

I am, Sir, yours truly,

W. LE POEB TRENCH, Colonel.

St. Huberts, Gerrard's Cross, Bucks,  
October 5th, 1901.

#### "A UNIQUE CASE OF GENERAL EMPHYSEMA FOLLOWING TRACHEOTOMY."

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In your issue of September 25th I notice, under the heading of "Clinical Records," a note by Mr. George Foy, F.R.C.S., of Dublin, on "A Unique Case of General Emphysema following Tracheotomy." He mentions the case of Dr. Ellett as being the only one he can find. I can add one more to the limited list.

The case occurred while I was junior house-surgeon at the Stanley Hospital, Liverpool, in 1896. It was one of two cases of diphtheria admitted within a few days of each other, both of which required tracheotomy, and in both of which the trachea became blocked below the tracheotomy wound, and in both of which we gently but thoroughly curetted the trachea for the removal of the obstructing membrane. Both cases ended in complete recovery.

In the second case the child developed general surgical emphysema within a short time of the operation. Every square inch of the child's body-surface, from the crown of his head to the tip of his toe, presented the condition, and, if I remember rightly, it was some few weeks before it entirely disappeared. My colleague, Dr. J. Ianston Dick, F.R.C.S., who was senior house surgeon, reported both cases in the *Lancet* of 1896, but neither of us thought or knew that the general emphysema was such a rare condition, and the fact that it did occur was merely mentioned, our great object in reporting the cases being to draw attention to a means of dealing with a generally fatal complication of diphtheria after tracheotomy. It is doubtless owing to this fact that Mr. Foy overlooked the case. I have not the copy of the *Lancet* by me, so cannot say what the child's age was, but I know it was quite young, being small enough for a child's cot.

Dr. Dick, who reported the case, is now practising in South Africa, or he would doubtless have sent you this little information himself.

I am Sir, yours truly,

F. DEAS.

Merton Park, S.W., October 5th, 1901.

### Literature.

#### ROSE AND CARLESS' MANUAL OF SURGERY. (a)

SUCH has been the success of this modern treatise on surgery that in less than three years three editions have been disposed of, and the demand for a fourth has been so rapid that the authors confess in their preface to it that "it has not appeared necessary to make many alterations in the text or in the illustrations, and hence this edition is practically a reprint."

We congratulate the modern medical student on

(a) "A Manual of Surgery for Students and Practitioners." By Wm. Rose, M.D., B.S. Lond., F.R.C.S., Professor of Clinical Surgery in King's College, London, and Albert Carless, B.S., F.R.C.S., Surgeon to King's College Hospital. Fourth Edition. Pp. 1,182, illustrations 406. London: Baillière, Tindall, and Cox. Price 21s. 1901.

possessing a text-book so clear, terse, and full; with such an aid his examinations should give him no trouble. For the practitioner the book is sufficiently full and so eminently practical as to be for him a trustworthy guide in any ordinary operation he may be called upon to perform. Moreover, as a book of reference it will be found a trustworthy *vade mecum* of modern practice, clothed withal in such felicitous language that dry details become pleasant reading and the memory aided with the facts set forth. As we reviewed fully the third edition but a few months since, and the one before us is practically the same book with only necessary corrections, we content ourselves on the present occasion by announcing the appearance of a fourth edition, advising all who have it not, whether practitioners or students, to possess themselves of it.

#### THE COMMONWEALTH OF CELLS. (a)

THIS is, in a sense, a popular treatise on physiology. The author has set himself the task of explaining, or rather of describing, the organs of the human body and their functions, in a genial narrative free from repellent technicalities. There is, however, a wide difference between this commendable little work and what is sometimes described as "popular physiology." The author does not attempt to be humorous or even sprightly, but he starts with the cell, defines its characteristics and properties, its composition and chemistry, and then proceeds to show how the cell becomes specialised and assists in carrying on the complex mechanism which is the animal organism. His limpid text is illustrated by numerous original diagrams which will appeal to the vulgar, and may be trusted to convey ideas which words can but inadequately portray.

We cannot help asking ourselves for what class of readers the author has written. We do not believe that his essays will successfully appeal even to the lower grade of science students, but to the educated person who yearns after a coherent and untechnical account of his own organism they will doubtless prove exceedingly welcome. Moreover, those who are engaged in lecturing on physiology, even to medical students, will find many happy and original suggestions in these pages which have been very carefully thought out.

#### ANDREWS ON PUBLIC HEALTH LABORATORY WORK. (b)

THIS is a collection of lectures delivered by the author to surgeons under instruction at Haslar. The lectures are divided into three parts. Part I. deals with the inspection of fish, flesh, and fowl intended for human food; Part II. with the examination of water, air, milk, various other foodstuffs and wines; while Part III. is devoted to the subject of meteorology and the bearing of atmospheric conditions on health and disease. Although the three parts are bound in one volume each division has its separate index immediately following, an arrangement which obviously presents drawback in looking up references.

The material is conveniently distributed and is set forth with commendable brevity. There is an appendix to Part I. on the tuberculin test for tuberculosis. The author throughout abstains from stating "views," giving his facts didactically and without comment. The text is illustrated by a goodly number of illustrations of the type with which we are familiar.

The attention given to meteorology in this volume is evidence of the increasing importance of this branch of study. The subject is a wide one, and the author has had to be very brief in his remarks. He describes the barometer and its use at some length as a preliminary to his observations on climate—climate being defined as "meteorological conditions dependent upon temperature and relative humidity." Directions are given for establishing the means of heat and humidity, together

(a) "The Commonwealth of Cells." By H. G. F. Spurrell, B.A. Oxon. London: Baillière, Tindall and Cox. 1901. Price 2s. 6d.

(b) "Hand-Book of Public Health, Laboratory Work, and Food Inspection." By O. W. Andrews, M.B., B.S., D.P.H.C. (M.S.) &c., late Assistant Instructor to Surgeons on Entry, Royal Navy. London: Baillière, Tindall and Cox. 1901. Price 7s. 6d.

with information bearing on the significance of "weather signs."

The work will be found very useful, not only to naval surgeons, but also to students preparing for a diploma in public health. We must, however, enter a protest against the use of glazed paper which is very trying to the eyes.

#### TREVES' SURGICAL APPLIED ANATOMY. (a)

THIS well-known manual is now presented in the form of a new and revised edition, compiled with the assistance of Mr. Arthur Keith, M.D., F.R.C.S., Lecturer on, and Senior Demonstrator of, Anatomy at the London Hospital. Applied anatomy may be taken to mean anatomy as it concerns the surgeon, and it deals with practical aspects of anatomy as distinct from the purely scientific description. Certain peculiarities of arrangement or structure, which possess no particular significance for the student of anatomy, possess considerable importance from a surgical point of view, and the object which the authors of such a manual as this have before them is to place these peculiarities in bold relief.

We have nothing but praise for the way in which the authors have fulfilled their task. The descriptions are brief, lucid, and to the point, in fact those who know Sir Frederick Treves will recognise his style in the text. The work can be confidently recommended to students preparing for examination.

#### HEALTHY HOMES. (b)

THIS is a very handy little work for intelligent persons who are desirous of learning what is healthy and the reverse in connection with house construction. Of course, as the author points out, no book, big or little, will make a man an expert, but this is a branch in which even a little knowledge is by no means a dangerous thing. The author has gone very thoroughly into the subject, neglecting no detail, even to the manner in which the housemaid should be instructed to sweep carpets, for there appears to be a right and a wrong way of discharging even this simple function. We are, however, unable to find any reference to earth closets, a method of disposing of excreta which has much to commend it, especially in rural districts. No previous knowledge of the subjects referred to is assumed, the simplest language is used throughout, and no scientific or technical term is employed without explanation, so that it is open to the general public to obtain a very fair knowledge of what constitutes "a healthy home."

#### GIBSON'S TEXT-BOOK OF MEDICINE. (c)

THIS work is "the united efforts of several writers who represent different important schools in the United Kingdom," under the editorship of Dr. G. A. Gibson. The term "Text-Book," to some persons, suggests a work designed for the use of students; to others it may not bear this meaning. If the work under consideration was brought out primarily for the student of medicine, its multiple authorship is distinctly unusual. At first sight it would appear that plural authorship should be a distinct advantage, but further consideration leads us to think that this is quite open to question. The student reads his book throughout; the busy practitioner turns up a special article for reference and to refresh his mind on one subject. The style affects the former much more than the latter, and it does not do, when one has become accustomed to a certain style—a simple one, perhaps—to find, on turning a leaf, another style utterly different, and perhaps difficult. Many text-books for students have been written; not many have "caught on," their style did not suit, they contained the required information, but, as with some teachers,

they did not readily impart it so as to suit the average learner, and thus were not a success.

Some of the articles before us, as, for instance, Prof. Kanthack's section on the "General Pathology of Disease," are too academic for the average general student of medicine, and are addressed more to the post-graduate student. For example, in acute inflammation:—"To select phagocytosis, or chemiotaxis, or new formation and repair as essentials, and make them corner-stones of theories of inflammation, is unjustifiable. Phagocytosis, chemiotaxis, and proliferation are concomitant, or it may be constant, phenomena of acute inflammation, and each one of these may be traced back from the highest to the lowest form of animal; but surely it is not sound reasoning to evolve the whole process of inflammation from one or two of its phenomena, especially when such phenomena are very primitive protoplasmic properties. Evolution may teach how a property or a character has been acquired; it may indicate something of the phylogenetic origin of an organ or process; but it nowhere teaches that a complex process in a higher animal type, which can be traced back to some property or function in a lower type, is identical with this property or function. In any appeal to evolution, the thread is often lost, and many gaps cannot be filled." This is not addressed to the undergraduate student. On the other hand, some sections have all the appearance of being written for the undergraduate. The articles on the Hæmopoietic system, for instance, give within a space of fifty pages all the main points of importance, but they pass over with disappointing brevity most of the recent work which has appeared with such abundance in this direction. We find it difficult, therefore, to decide from internal evidence for which class of students this text-book before us is intended. This also makes us hesitate before we conclude that multiple authorship of a text-book of medicine is a distinct advantage to the undergraduate student.

In the preface we read that "certain symptoms, occasionally dignified by the title of separate diseases, will be sought in vain under individual headings, but will be found as parts of the subjects to which they properly belong." We were surprised, therefore, to find that the very first subject treated under the section on diseases of the liver is "Jaundice." Selecting typhoid fever for survey from among the fevers met with commonly in this country, we must confess to a feeling of disappointment. *Taches bleuâtres* have nothing to do with the rash of typhoid any more than flea-bites have. To place them in a paragraph describing the eruption, without any notice of their occurrence in other fevers, or any explanation of their probable origin, is misleading. A work published in 1901 might be expected to discuss, if it did not advise, the surgical treatment of perforation, which has aroused interest in the surgical world, in which considerable work has been done, and in which some, though unfortunately little, success has been obtained. The whole matter is dismissed as follows—"If surgical interference is undertaken it should be within twelve hours of the perforation, if it is to have much chance of success." The chief onus as to the success or otherwise lies therefore with the physician, but when we turn to the text for the diagnosis of this "the most dreaded of all symptoms" (complications, we should say) we find that there is not a single word about either the pulse or temperature. There is a small chart to illustrate a case of perforation, but no attention is drawn to its salient points in the text.

Nearly half a page is taken up with Ehrlich's *diazoreaction* in the urine, as a diagnostic, which we consider absolutely useless, as it is present in so many other febrile states. Under "Prophylaxis" there is not a word about Wright's anti-typhoid inoculation, four-and-a-half lines being sufficient to mention it earlier in the chapter under "Immunity."

In the discussion on modes of spreading the disease, and later, on disinfection, there is no mention at all of the urine, a subject which has excited much interest elsewhere. As regards general management, we read: "It

(a) "Surgical Applied Anatomy." By Sir Frederick Treves, K.C.V.O., C.B., F.R.C.S., Consulting Surgeon to the London Hospital, &c. London: Cassell and Co., Limited. 1901.

(b) "A Healthy Home." By Francis Vacher, County Medical Officer for Cheshire, &c., &c. Second Edition. London: The Sanitary Publishing Company.

(c) "Text-Book of Medicine," in Two Volumes. Edited by G. A. Gibson, M.D., F.R.C.P.Ed., Physician to the Royal Infirmary, Edinburgh, Edinburgh and London: Young J. Pentland. 1901. Two Vols. Price 25s. net.



(milk) should not be given too often, nor in too great quantity. About four ounces, given every two-and-a-half or three hours, will probably be found to agree well." Four ounces every three hours works out: 32 ozs. = 1 pt. 12oz. in twenty-four hours; but a line and a-half lower down we read, "The total quantity given in twenty-four hours should not, as a rule, exceed two-and-a-half or three pints" (the italics are ours). The unhappy post-graduate who applies here for help in his first case of enteric will not, we hope, consider that it is a matter of no concern whether he gives the patient one and-a-half or three pints of milk in the twenty-four hours.

The question of stimulants is well discussed, but in the sentence "It is seldom that more than 6 or 8 ozs. in the twenty-four hours are demanded" we would leave out the words "more than." "Diarrhœa, if slight, may require no special treatment" is too vague. If the bed-pan is used constantly, four, five, or six motions will be found a usual number, and not call for any treatment; if the bed-chair is used, one, two, or three will be the usual number, and over four will require to be strictly watched and probably treated.

On the subject of epidemic cerebro-spinal meningitis there is no mention of "lumbar puncture" as a means of diagnosis either ante- or post-mortem. The diseases more commonly met with in foreign countries are admirably treated by Dr. Patrick Munson. The articles are a model of clear, concise writing; short but full of information, without a line that could be omitted, making most attractive reading even to one not directly interested in the subjects. The chapter on Malaria gives, it is needless to say, everything worth knowing, and contains numerous illustrations. Dr. Munson is also responsible for the section on Diseases caused by Animal Parasites, and here again we are treated to a splendidly condensed and well illustrated article, complete and up to date. It seems strange that in the article on Cancer of the Stomach there is no mention of the presence or absence of H Cl in its contents, as an aid to diagnosis. The only reference to it is:—"Secretion may not at once be effected, but as the disease progresses the hydrochloric acid diminishes." This under the sub-head "Morbid Anatomy."

In "Diseases of the Blood," vol. ii., p. 14, "cadaveric bodies, formed in the intestinal canal," we prefer the term cadaveric substances, "bodies" sounds strange. Again, "The bone marrow is altered, especially in the ends of the long bones the yellow marrow being converted into deep red tissue." Surely the shafts of the long bones should be referred to here, not the ends. Tenderness of the bones is not mentioned at all under Pernicious Anæmia. Leucocythæmia must be diagnosed from several things, but pernicious anæmia does not appear to be one of them (p. 33). On p. 42, "the skin begins to secrete sweat and perspiration."

Addison's Disease is headed "Diseases of the Suprarenal Bodies," and we think the word "body" might have been used all through instead of "gland," as they are not glands in the ordinary acceptation of the term. The discussion of their glandular function would have been sufficient without dubbing them glands on every occasion. "The symptoms of Addison's disease . . . undoubtedly depend on abolition of the gland function" is very precise, but the next line reads "We are quite ignorant how this brings about the pigmentation, and we can only offer surmises regarding some of the other symptoms." Diseases of the kidney are thoroughly well handled. Here, however, the appearance of whole pages unbroken by a paragraph do not tend to lighten a heavy subject. We have nothing but praise for the section on the nervous system.

The book is excellently turned out and it is practically free from clerical errors, which we consider a feature of Scotch work. One, obviously an author's oversight, is in Vol. I., p. 25, where "castor oil" is cited instead of "croton," as an example of an irritant which may cause sterile suppuration. It is a cause of wonder that such progressive publishers still adhere to senseless page headings. For instance forty-two pages contain fourteen different subjects, but each page is headed on one side "Respira-

tory System," on the other "Diseases of the Lungs." The same applies in sixty-eight pages with fifteen subjects headed right and left "Diseases of the Kidney" and "Structural Diseases," but one must hunt through the whole sixty-eight pages for Acute Bright's Disease. This is worse than useless, it is a nuisance, and a waste of labour and printer's ink; better leave the page heads blank. It is less irritating, but a much more senseless custom than sending out a book with uncut leaves.

Also we regret the tendency to send out big, heavy books, and especially with glazed paper. Because of the weight they cannot be comfortably read except at a table, and on account of the reflection from the glazed paper they cannot be comfortably read unless the light comes directly from behind the reader, hence the difficulty of ever reading them with comfort. We think that our publishers, in this, are following a bad American lead.

## Medical News.

### THE ELECTION OF DIRECT REPRESENTATIVES TO THE GENERAL MEDICAL COUNCIL.

A WELL-ATTENDED meeting in support of the candidature of Dr. Glover was held on Friday evening, October 4th, at the residence of Dr. White, 1, High-bury Place, N., with Dr. Danford Thomas in the chair. Dr. Glover gave a brief statement of his position and views, after which Sir Thomas Barlow proposed the following resolution: "That this meeting, having heard from Dr. Glover a statement of the work of the Medical Council and of his views thereon, and having regard to his action in the three periods during which he has been one of the direct representatives of the profession in the Council, hereby expresses its unabated confidence in him, and its determination to do all in its power to ensure his successful re-election."

This resolution was seconded by Dr. Ford Anderson and carried unanimously, after Dr. A. G. Bateman had spoken in support.

Dr. Buckell then moved: "That this meeting, believing that Dr. Glover's re-election will be in the interest of the profession generally, as well as in that of the principle of direct representation, desires to commend his candidature to the heartiest support of all registered medical practitioners in England and Wales; who, it is hoped will, in their own interest as well as in that of the public, record a much larger vote at the coming election than on any previous occasion."

This resolution was seconded by Mr. Jago, and supported by Dr. Malcolmson, and was also carried unanimously. After the meeting had formed itself into a committee for the furtherance of Dr. Glover's election, and after a vote of thanks to the chairman had been proposed by Dr. Glover and seconded by Mr. Keele, the proceedings terminated.

#### Guy's Hospital Medical School.

The following entrance scholarships and certificates have been awarded—

Senior Science Scholarship for University Students: £50, Mr. A. F. Hertz; and certificates to Mr. W. M. Mollison, King's Coll., Cambridge, and Mr. E. C. Hughes, Clare Coll., Cambridge. Junior Scholarships in Science: Mr. P. B. Mills, Dulwich Coll., and Mr. W. Trethowan, Plymouth Technical School and Guy's Hospital, £105 each; and a certificate to Mr. C. M. Wenyon, University Coll., London. Entrance Scholarships in Arts: £100, Mr. C. Mayer; £50, Mr. M. J. Rattray, King's School, Bruton, Somerset; and certificates to Mr. T. E. A. Carr, Lancing Coll., Sussex, and Mr. K. J. Saunders, Clifton Coll.

#### St. Thomas's Hospital Medical School.

The following is a list of prizes distributed at the opening of the winter session at this school on Wednesday last:—Prizes for Winter Session, 1900-1: Entrance Science Scholarship: G. Y. Yorral, first scholarship, £150. University Scholarship: W. L. Harnett, scholarship, £50. First Year's Students: L.

E. C. Norbury, the Wm. Tite scholarship, £27 10s.; D. K. Coutts, College prize, £20; E. J. H. Cox, College prize, £10; A. W. Hooker, Second Year's Students: H. A. Kisch, the Musgrave scholarship, £38 10s.; E. W. Parry, College prize, £20; T. P. Puddicombe, College prize, £10; K. Takaki, Third Year's Students: H. S. Bennett and F. W. W. Smith, second tenure of Peacock scholarship. Fifth Year's Students: C. N. Sears, College prize, £10 (medicine); C. Burrows, College prize, £10 (surgery); R. E. Roberts, College prize, £10 (midwifery); W. M. G. Glanville, Hadden prize, £10 (pathology); C. N. Sears, College prize, £10 (pharmacology); H. W. Sinclair, College prize, £10 (forensic medicine and insanity); H. W. Sinclair, College prize, £10 (public health). Prizes for Summer Session, 1901: First Year's Students: L. E. C. Norbury, College prize, £15. Medals: W. M. G. Glanville, the Wainwright prize in practical medicine; J. E. H. Sawyer, the Bristowe medal for pathology and morbid anatomy; C. N. Sears, the Treasurer's gold medal for general proficiency and good conduct.

#### University College.

**MEDICAL Entrance Scholarships.**—Bucknill Scholarship, £30 a year for four years, J. A. Watt; 60 guineas scholarship, H. R. Evans; 60 guineas scholarship, L. F. Hirst. Medical Exhibitions, each 80 guineas, J. A. Ferrière and E. E. Maples.

#### Westminster Hospital Medical School.

THE Annual Dinner of the Past and Present Students took place at the Hotel Cecil on Friday evening last, Mr. Charles Stonham, F.R.C.S., in the chair. There was a very large gathering of students and their friends.

After the usual loyal toasts the Chairman proposed the toast of the evening, "Students Past and Present," and he remarked that although Westminster ranked among the smaller schools its students contributed more largely, in proportion to its size, to the services than any other school in Great Britain. Mr. Stonham appealed to past students to stand by the institution and to aid so far as they could in its progress. He then referred at some length to the events in South Africa and to the part in the campaign played by himself and the students, &c., who had accompanied him as dressers, &c. In order not to be accused of favouritism he carefully abstained from promoting any of the medical students under his command from their position of privates, an austerity which was doubtless appreciated by those who had to bear the burden. He spoke most highly of the way in which his men had discharged their duties under what were often very trying circumstances. The toast was responded to by Mr. J. W. Batterham and Mr. G. L. Bunting. The toast of "The Medical School" was proposed by Dr. Alchin, who discussed the probable influence of the reconstituted University of London on medical education in the metropolis, and was responded to by Mr. A. H. Tubby. A very pleasant evening was spent, musical interludes being rendered by Mr. Pearson, Mr. G. W. Hodgson, Mr. Fred Wright, Mr. Trebelli, and others. The Entrance Scholarships competed for before the beginning of the winter session have been awarded as follows:—Epsom Scholarship, of the value of 110 guineas, to Mr. J. M. Platt; Scholarship in Arts, of the value of £60, to Mr. R. S. Statham, from Dover College; Natural Science Scholarship, of the value of £60, to Mr. A. C. Bryson; University Scholarship, of the value of £40, to Mr. J. H. Hebb, from St. John's College, Oxford; Scholarship in Arts, of the value of £40, to Mr. H. Galloway, from St. Paul's School; and a Scholarship in Arts, of the value of £30, to Mr. C. C. Hickey.

On Saturday last a new electrical laboratory and Röntgen-ray room was opened at Westminster Hospital, having been built and equipped by private donations at a cost of about £1,000.

#### Doctors on Strike.

ACCORDING to the *Pall Mall Gazette*, the junior medical staff of the Civil Hospital at Venice, twenty-seven in number, have just sent an "ultimatum" to the governors demanding a complete reorganisation of the sanitary conditions of the hospital, an increase of their own

salary, and an augmentation of their numbers. Failing a satisfactory reply, they threaten to strike in a body. The governors, supported by the municipal and Government authorities, besides refusing any concession, have determined to replace all the signatories, who are at the same time held criminally responsible for leaving their posts before their successors are appointed.

#### A Bogus Doctor.

SOME curious facts came to light at an adjourned inquest held last week on the body of a seaman at West Ham. He had been medically treated by a person called Head, who posed as an unqualified medical assistant of forty-one years' experience. On his plate he described himself as "Surgeon Dentist and Accoucheur," although he did not pretend to be a registered dentist. His therapeutical armamentarium consisted in some burnt sugar, Epsom salts, and bicarbonate of soda, none of which was likely to afford much relief in pleurisy of old standing which had degenerated into empyema, from which, as the autopsy showed, the man had died. The jury found that death had been accelerated by the gross ignorance of Head, for whose presence as witness a warrant had had to be issued, and thereupon the coroner committed him for trial on a charge of manslaughter.

#### A Medical Man Charged with Fraud.

AT Todmorden, last week, Dr. J. Cubbin, of Char-nock Pritchard, near Chorley, was charged with obtaining money by false pretences. Prisoner called upon the Vicar of Mytholmroyd, and representing that he had secured a clerkship in Bradford, and, being penniless, had tramped from Blackburn, the Vicar (Mr. Walton) gave him a few shillings to pay his railway fare and get something to eat. Several charges are pending, and he was remanded for inquiries.

#### Fall from a Train.

THE body of a man was discovered on the Great Western Railway, not far from Chippenham, last week, he having apparently fallen from an express train. On him was found a card bearing the name of Dr. Reid Crow, who, it was stated, had recently arrived from South Africa.

#### A Serious Accusation.

DR. WILLIAM TYNDAL WATSON, medical officer of health to the Tottenham District Council, is under remand on a charge brought under the Criminal Law Amendment Act. On hearing that a warrant had been issued for his arrest Dr. Watson, who was absent on his holiday, at once returned and presented himself at the police station.

#### Typhoid Fever in Germany.

A SERIOUS epidemic of typhoid fever is raging at Gelsenkirchen, the number of cases up to the present being estimated at upwards of 1,300. The outbreak is attributed to the unsanitary condition of the district and an impure water supply.

#### A Surgeon charged with Fraud.

A MAN called Robert Wilson, aged 44, described as a surgeon, and shabbily dressed, has been remanded on a charge of attempting to obtain money by false pretences from Dr. Theodore Dyke Acland and others by pretending that he was Dr. William Dyer Fraser, who is at present in South Africa.

#### An Unconscientious Objector.

A MAN applied to the Bromsgrove magistrates last week for a certificate of exemption for his child, on the ground that he believed it would be injurious to his child by causing unnecessary pain. He was informed that this did not constitute a conscientious objection, but in answer to a question he said he could not conscientiously declare that he believed that vaccination would be injurious to the health of his child. The certificate was accordingly refused, but we agree with the magistrates that the applicant "was about the first for whose opinions they had any respect."

#### Death under Chloroform.

A LAD, sixteen years of age, died from the effects of chloroform last week at Wimslow, near Manchester, when about to undergo an operation on the mouth.

**Annual Medical Service at St. Paul's.**

THE annual medical service at St. Paul's Cathedral will take place on Thursday, October 17th, at 7.30 p.m. As in past years, many members of the medical profession have signified their intention of attending in academical robes. The arrangements of the service this year have been considerably modified with a view to make it simpler and brighter. The sermon will be preached by the Rev. Canon Gore, and the music rendered by the London Choir Association, the choir being conducted by the Rev. Dr. H. Walford Davis, organist of the Temple Church. Admission to the spaces under the dome will be by ticket only.

**A Tribute to a Victim of Science.**

THE tablet to the memory of the late Dr. Walter Myers, of Birmingham, given by the Liverpool School of Tropical Medicine, is now fixed within the walls of the Birmingham University. It will be remembered that Dr. Walter Myers died of yellow fever, in his 29th year, last January, at Para, Brazil, whilst investigating the pathology and etiology of that disease for the Liverpool school. Dr. Myers was educated at the High School, New Street, Birmingham, and went from there for a time to the then Mason College, which he left after gaining an open scholarship in natural science, at Caius College, Cambridge.

**Vital Statistics.**

THE deaths registered in the week ending September 28th in 36 large towns of Great Britain and Ireland corresponded to an annual rate of 16.7 per 1,000 of their aggregate population, which is estimated at 11,463,026 persons in the middle of this year:—

Birkenhead 15, Birmingham 21, Blackburn 17, Bolton 16, Bradford 12, Brighton 16, Bristol 13, Burnley 17, Cardiff 12, Croydon 10, Derby 12, Dublin 17, Edinburgh 16, Glasgow 15, Gateshead 22, Halifax 17, Huddersfield 15, Hull 20, Leeds 19, Leicester 9, Liverpool 18, London 15, Manchester 21, Newcastle-on-Tyne 25, Norwich 19, Nottingham 13, Oldham 16, Plymouth 13, Portsmouth 16, Preston 18, Salford 17, Sheffield 20, Sunderland 27, Swansea 19, West Ham 17, Wolverhampton 17. The highest annual death-rates per 1,000 living, as measured by last week's mortality, were:—From fever, 1.1 in Huddersfield, 1.3 in Hull, and 1.4 in Sunderland; and from diarrhoeal diseases, 3.3 in Blackburn and in Sheffield, 3.5 in Hull, 4.2 in Oldham, 4.6 in Sunderland, 5.0 in Wolverhampton, and 5.7 in Gateshead. In none of the large towns did the death-rate from scarlet fever reach 1.0 per 1,000. The 83 deaths from diphtheria included 34 in London, 10 in West Ham, 5 in Bristol, 5 in Liverpool, 5 in Manchester, 4 in Bolton, 3 in Cardiff, and 3 in Salford. Five deaths from small-pox were registered in London, but not one in any other of the large towns.

**A Crematorium for Variolous Dead.**

THE Works Committee of the Metropolitan Asylums Board have under consideration a proposal to erect a crematorium at the Joyce Green Hospital for the disposal of the bodies of those who die of small-pox.

**On the Altar of Science.**

DR. J. E. O'BRIEN, of Lowestoft, wishes to emulate the devotion of Dr. Gerault, the French physician who some time since offered himself as a subject for experiment in regard to the transmissibility of tuberculosis from animals to man. Professor Koch naturally enough declined the responsibility of inoculating the applicant, but advised him as an alternative to drink the milk of a tuberculous cow under a restricted diet for twelve months. According to the reports before us this tedious experiment does not satisfy the aspirations of this would-be victim to science, who sighs for intravenous injections of highly virulent bacilli or other dramatic method of arriving at a conclusion. Such experiments are to be discouraged in view of the fact that there is so much scope for fallacy that, be the result what it may, no trustworthy deduction would be possible. We fear that a thirst for notoriety has as much to do with these offers of self-immolation as devotion to science.

**Dublin Death-rate.**

In the Dublin Registration Area for the week ending

September 28th, 1901, the deaths registered represent an annual rate of mortality of 18.5 in every 1,000. During the thirty-nine weeks ending with Saturday, September 21st, the death-rate averaged 26.6. Twenty-eight infants under one year of age, of whom six were under one month old, died during the week. Fourteen infants died between the ages of one year and five. Diseases of the respiratory system caused twenty deaths, of which twelve were caused by bronchitis and seven by pneumonia. In three instances of infants under one year of age the deaths were uncertified, there having been no medical attendant during the last illness.

**Pass Lists.**

**University of Durham Faculty of Medicine.  
THIRD EXAMINATION.**

THE following candidates for the degree of Bachelor in Medicine have satisfied the examiners:—

Honours.—Second Class: Chella Mary Hankin, Arthur Gibson Dunn, Charles Harold Crass.

Pass List.—Thomas Engelhart Amyot, Robert Story Browne, Annie Tombleson Brunyate, Ambrose Harold Bateman, William Morton Emmerson, Francis Jollie Gowans, Bryden Glendining, James William Gibson, Daniel Richard Guns, William George Thomas Hepplewhite, Lizzie Evelyn Kendal, Flora Murray, Thomasina Georgina Prosser, Briton Smallman Robson, Joseph Collingwood Stewart, Marmaduke Cordeux Wetherell, Auburn Lawrence Wilkinson, John Robert Wylie.

Doctor in Medicine.—Henry Edward Davison, M.B., B.S., B.Hy., Durh.; Herbert George Harris, M.B., B.S., Durh.; Henry Douglas Johns, M.B., B.S., Durh.; Albert Ezra Neale, M.B., B.S., Durh.; Vaughan Pendred, M.B., Durh., F.R.C.S.; Arthur Riley, M.B., B.S., Durh. (*in absentia*); Frederick William Rowland, M.B., B.S., Durh.; Alfred Edward Stevens, M.B., Durh.; Ralph Harry Vincent, M.B., B.S., Durh., M.R.C.P.; Leslie Herbert Walsh, M.B., B.S., Durh.

Doctor in Medicine for Practitioners of Fifteen Years' Standing.—William Robert Etches, M.R.C.S., L.R.C.P., D.P.H.; Charles Joshua Joseph Harris, L.S.A., M.R.C.P., D.P.H.; John Henry Harris, M.R.C.S., L.S.A., D.P.H.; Edwin Guy Hunt, M.R.C.S., L.R.C.P.; James Thomas Neech, L.R.C.P., L.M., L.F.P.S.G., D.P.H.; William Henry Wright, M.R.C.S., L.K.Q.C.P., I., L.S.A.

Master in Surgery.—Bertram Crossfield Stevens, M.D., B.S., F.R.C.S., E., M.R.C.S., L.R.C.P., L.S.A.; George Grey Turner, M.B., B.S., Durh., M.R.C.S., L.R.C.P.

Bachelor in Medicine (M.B.).—Curtis Crispin Adeniyi-Jones; Arthur John Spiller Brandon, M.R.C.S., L.R.C.P.; Clifford Harold Brookes, L.S.A.; Thomas Seymour Coates; George Ernest Froggatt; Philip Gell Garrett, M.R.C.S., L.R.C.P.; Charles Henry Gibson; John Spencer Hall, M.R.C.S., L.R.C.P.; Robert Simpson Hindmarch; Albert Ernest Hodge; Ernest George Klumpp, M.R.C.S., L.R.C.P.; Ernest Edward Norman; Alfred Parkin; George Woodyatt Procter, M.R.C.S., L.R.C.P.; Frederick Riddle Scott; John Ernest Sidgwick; Richard Thorne-Thorne, M.R.C.S., L.R.C.P.

Bachelor in Surgery (B.S.).—Curtis Crispin Adeniyi-Jones; Arthur John Spiller Brandon, M.R.C.S., L.R.C.P.; Thomas Seymour Coates; George Ernest Froggatt; Philip Gell Garrett, M.R.C.S., L.R.C.P.; Charles Henry Gibson; John Spencer Hall, M.R.C.S., L.R.C.P.; Robert Simpson Hindmarch; Ernest George Klumpp, M.R.C.S., L.R.C.P.; Ernest Edward Norman; Alfred Parkin; Frederick Riddle Scott; John Ernest Sidgwick; Alfred Edward Stevens, M.B.; Richard Thorne-Thorne, M.R.C.S., L.R.C.P.

Bachelor in Hygiene (B.Hy.).—Thomas Morrison Clayton, M.B., B.S., Durh.; Thomas Yeates, M.B., C.M., Ed.

And the following gentlemen received the Diploma in Public Health, (D.P.H.), viz., Thomas Morrison Clayton, M.B., B.S., B.Hy., Durh.; Henry Edward Davison, M.B., B.S., B.Hy., Durh.; Duncan Macfadyen Millar, M.B., C.M., Glas., B.Hy., Durh.; Edgar Mitchell, M.D., B.S., B.Hy., Durh.; Thomas Yeates, M.B., C.M., Ed., B.Hy., Durh.

## Notices to Correspondents, Short Letters, &c.

✉ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

ORIGINAL ARTICLES or LETTERS intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication, but as evidence of identity.

One would think, remarks the N.Y. *Medical Record*, that when a novelist had once been convicted of gross ignorance on medical matter concerning which he wrote with glibness, he would not make a second incursion in that dangerous field unless he was fairly sure of his ground. Not so Mr. Hall Caine (though perhaps we err in dignifying him with the title of novelist). In his latest effort, "The Eternal City," he describes how a medical man examined the breast of a patient and the glands under her arms, and, finding cancer, announced that a nurse must be summoned immediately. This practitioner, who is supposed to be the most fashionable doctor in Rome, tells the friends a few pages further along in the dreary tale that if the cancer had been diagnosed earlier "nephrectomy" might have been possible, but that the case as he found it was beyond the reach of surgery.

MIRABILIS.—Our correspondent would not be justified in taking such a step.

### A STUDY IN EMBRYOLOGY.

By F. B. SAWYER, M.D., MARION, O.

In an ovary one night was an ovum just right for the process of ovulation.

As she passed from her lair she was caught on the hair of the fibrinated prolongation.

In the tube to the right was a full armoured knight, desiring to produce fecundation.

She complies then and there and begins to prepare by her polar globule formation.

For before they could meet in this vitalline street by an arch of cell germination,

She must accomplish a feat, in its way very neat, to prevent parthenogenesis.

Then the knight wiggles in to the temple of sin where the idol of his adoration,

Full of vigour and vim, is awaiting for him to fertilise her pro-nucleation.

As he entered this pole, he exclaimed with a wail, in accents of great desperation,

"I am minus my 'tail,' and I'm sure I shall fail to fully induce impregnation."

But she meets him half way, saying "Do not dismay," affording him much gratification;

So together they stay, and the devil's to pay, for there's formed a new nucleation.

Then changes take place at a very fast pace, a process called segmentation,

And in most every case, to the end of the race, there follows the time of gestation.

—Cincinnati *Lancet-Clinic*.

DR. S. (Croydon).—We do not see our way to adopting your suggestion, as to do so would place us in a false position towards the vendor of the drug in question. There appears to be no reason why

J. B. M. (Scutport).—The vaporisation of a solution of strong ammonia in a room which has been disinfected with formalin is stated to obviate the irritating effects of the latter on the respiratory tract. This can be injected through the keyhole, or ammoniac gas may be passed in through a tube. In this way urotropin, a comparatively inert product, is formed.

## Meetings of the Societies.

WEDNESDAY, OCT. 9TH.

HUNTERIAN SOCIETY (London Institution, Finsbury Circus, E.C.1).—8.30 p.m. Dr. Mitchell Bruce: Chest Complications in Abdominal Disease. (Hunterian Lecture.)

DERMATOLOGICAL SOCIETY OF LONDON (11, Chandos Street, Cavendish Square, W.).—5.15 p.m. Demonstration of Cases of Interest.

THURSDAY, OCT. 10TH.

BRITISH GYNECOLOGICAL SOCIETY (20, Hanover Square, W.).—8 p.m. Specimens will be shown by Dr. H. Macnaughton Jones Dr. Travers: Intestinal Obstruction caused by Unsuspected Uterine Fibromyoma simulating Appendicitis.

FRIDAY, OCT. 11TH.

CLINICAL SOCIETY OF LONDON (20, Hanover Square, W.).—8.30 p.m. Papers.—Mr. J. J. Clarke: Note on a Painful Condition of the Twelfth Pair of Ribs.—Mr. T. Bryant: A Case of Displaced Strangulated Femoral Hernia.—Mr. C. Wallace: Wounds of Joints and their Treatment.—Mr. C. Manneil Moullin: Omental Fixation for Ascites.

THURSDAY, OCT. 17TH.

HARVEIAN SOCIETY OF LONDON (Stafford Rooms, Titchborne

Street, Edgware Road, W.).—8.30 p.m. Mr. Campbell Williams will read a paper on "Hæmaturia in Childhood."

## Appointments.

BAILEY, J. C. M., M.B.Lond., M.R.C.S., L.R.C.P.Lond., House Physician and House Surgeon to the West London Hospital.  
FETHERSTON, R. H. J., M.B.Edin., L.R.C.S.Irel., Acting Officer of Health for the City of Prahran, Victoria.  
FINDLAY, JOHN, M.B., M.Ch.Aberd., Second Assistant Medical Officer, Dorset County Asylum.  
NOALL, WM. PAYNTER, M.B.Lond., M.R.C.S., L.R.C.P., Surgeon to the East London Hospital for Children, Shadwell.  
RICHMOND MARSHALL LEIGH, L.S.A.Lond., Medical Officer and Public Vaccinator to the Mary Tavy District of the Tavistock Union.  
THORNTON, E. G. C., M.B., B.A.O., R.U.I., District Medical Officer of Wellington (Salop).  
WARNER, ALLAN, M.D.Durh., M.R.C.S., L.R.C.P.Lond., Resident Medical Officer of the Leicester Isolation Hospital.

## Vacancies.

Belfast, Royal Victoria Hospital.—Medical Superintendent. Salary commencing at £300 per annum, with board and residence. Applications to the Hon. Sec. (See Advt.)  
Bristol General Hospital.—Assistant House Surgeon. Salary £70 per annum, with board, residence, &c. Applications to the Secretary.  
Burton-on-Trent Infirmary.—House Surgeon. Salary at the rate of £120 for the first year and £140 for the second year, with board, furnished rooms, &c. Applications to the Hon. Secretary, the Infirmary, Burton-on-Trent.  
Clayton Hospital and Wakefield General Dispensary.—Senior House Surgeon, unmarried. Salary £120 per annum, with board, lodging, and washing. Applications to the Hon. Secretary.  
Cliffden Union.—Medical Officer. Salary £140 per annum as Medical Officer, and £10 a year as Medical Officer of Health, with the usual Registration and Vaccination Fees. Applications, accompanied by diplomas and testimonials to F. King, Clerk of Union. (See Advt.)  
Cornwall County Asylum, Bodmin.—Junior Assistant Medical Officer, unmarried. Salary £120, rising to £150, with board, apartments, laundry, &c.  
County Asylum, Mickleover, Derby.—Senior Assistant Medical Officer. Salary £130, rising to £150 per annum, with apartments, board, washing, and attendance. Also Junior Assistant Medical Officer. Salary £110, rising to £130 per annum, with apartments, board, washing, and attendance. Applications to the Medical Superintendent.  
Denbighshire Infirmary, Denbigh.—House Surgeon. Preference given to one having a knowledge of the Welsh language. Salary £100 to commence, with board, residence, and washing. Applications to the Secretary.  
Essex County Asylum, Brentwood.—Junior Assistant Medical Officer. Salary £140 per annum. Apply to the Medical Superintendent.  
Glasgow Royal Asylum for Lunatics.—Physician Superintendent. Salary £1,000 per annum, with a house at the Institution and free coal, gas, and water-supply. Applications to the Secretary, Glasgow Royal Asylum for Lunatics, 190, West George Street, Glasgow.  
Ingham Infirmary.—Senior House Surgeon wanted. Salary £100 per annum, with residence, board, and washing. Applications to the Secretary, 74, King Street, South Shields.  
Manchester Children's Hospital, Pendlebury.—Medical Officer. Salary £180 per annum. Applications to the Secretary.  
Midlothian District Asylum.—Assistant Medical Officer, single. Salary £200, with furnished rooms, board, washing, and attendance.  
North Staffordshire Infirmary and Eye Hospital, Hartshill, Stoke-upon-Trent.—House Physician. Salary £100 per annum, increasing £10 per annum, with apartments, board, and washing. Applications to the Secretary.  
North Wales Counties Lunatic Asylum, Denbigh.—Second Assistant Medical Officer. Salary £120 per annum, rising to £160, with board, residence, and washing. Applications to the Clerk of the Visiting Committee.  
St. Mary's Hospital Medical School, Paddington, W.—Casualty Physician. Salary £75 per annum.

## Marriages.

GOODFELLOW—ROBERTSON.—On Sept. 25th, at St. Wilfrid's Church, Northenden, Cheshire, Thomas Ashton Goodfellow, M.D.Lond., of Didsbury, to Eleanor Winifred, only daughter of W. J. Robertson, of Northenden.  
MORGAN—FROSSER.—On Oct. 2nd, at Llanarthney Parish Church, Wales, Edwin Morgan, L.D.S.Eng., youngest son of the late W. Evans Morgan, M.R.C.S., L.R.C.P.Lond., to Margaret Agnes, youngest daughter of W. W. Frosser, of Capel Dewi Hall, Carmarthen.

## Deaths.

KING.—On Oct. 2nd, at 13, Eton Road, South Hampstead, Anne Parsons King, widow of the late Abraham King, M.D., of Bridgwater, Somerset, in her 75th year.  
ROOSE.—On Oct. 1st, Edith, wife of Robson Roose, M.D.Bruce, F.R.C.P.Ed., of Hill Street, Berkeley Square, London; aged 50.

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## Clinical Lectures.

### RAYNAUD'S PHENOMENA :

BEING THE ABSTRACT OF A LECTURE DELIVERED  
AT THE LONDON HOSPITAL, ON JUNE 19TH, 1901.

By JONATHAN HUTCHINSON, F.B.S., &c., &c.

GENTLEMEN,—It is always pleasant to an old man to renew the avocations and pleasures of his youth, and so I come before you with a subject which reminds me of my work in the wards of the London Hospital, where I believe some of the earliest cases of "Raynaud's disease" in England were observed and studied, and where the first observation was made as to the connection between paroxysmal hæmaturia and Raynaud's disease.

First, I think we shall gain a clearer idea of our subject if we discard its name, for the expression "Raynaud's disease" would imply that there is some one malady complete in itself, and having all the symptoms the same in all cases which is suitably denominated by that name. That is not the case. We know what we mean by syphilis, variola, and pulmonary phthisis. Understand that I wish to do all honour to such a man as Raynaud—a man of singular originality of mind and of great pertinacity in observation, who devoted himself to the pursuit of clinical truth. But by being precise in the signification of the names we employ we shall be honouring his name, and therefore I would speak rather of Raynaud's phenomena than of Raynaud's disease, for the former are things which we understand and are the same in all cases. In this substituted expression we must include a large group of maladies which differ widely in their ætiology. What do we mean by Raynaud's phenomena? You are aware that local syncope, local asphyxia, symmetrical gangrene of the extremities are synonymous terms. More recently the prefix *acro-* has been applied as in (*acro-sphacelus*) i.e., gangrene occurring at the very extremities. I think it is a very useful term to employ in that connection. Under the different words we imply the knowledge that the circulation in the extremities is liable to be interfered with, and this interference may lead to malnutrition of the parts and to local symmetrical gangrene. To simplify our problem, we must remember we are all the subjects of Raynaud's phenomena in a greater or less degree. We are all liable not only to coldness of the hands through exposure, but also through the influence of the nervous system. Our next assertion will be that no two of us are alike. We are all different as regards the susceptibilities of our tissues and our circulation to be disturbed by separate influences. Thus we at once recognise the reality of personal peculiarity, and the importance of its recognition. The term "local syncope" is given to the phenomenon which is sometimes known as "dead finger." Some

persons, after undue exposure to cold of their hands, will be liable to have the circulation in those parts quite suspended. This condition depends on a spasm of the arteries supplying the finger, whereby its blood supply is cut off. It is attended by the condition of local asphyxia, in which the parts become not pale but very dusky and of a livid hue, though not shrivelled as in local syncope, where the finger would be like that of a corpse. Local asphyxia, in contradistinction to local syncope, is due to fulness of the small veins of the part; in both, the arteries are more or less affected by being thrown into spasm, but in the former the closure of the lumen is less complete.

Is it true that these conditions always or usually go together? We must not insist too strongly upon these phenomena having any relation in point of time to each other. Perhaps usually one condition does precede the other, the "pale" stage being followed by the "livid" condition. But in some persons the fingers become dusky straight off; in others they become pale first and remain so. In a great many cases there is a certain amount of dusky mottling and pallor mixed up together, as in a corpse.

In order to constitute a typical resemblance to Raynaud's phenomena the patient ought to be liable to have the phenomena in a paroxysmal manner. But there are cases which are not paroxysmal, which occur only once in the patient's life and then pass away and do not come again, and these cases must be considered with the others, although not exactly parallel. The periods of liability may sometimes extend over several weeks, during the great part of which the limbs remain in a state of extreme duski-ness or pallor. The phenomena may recur after a long time.

Should symmetrical gangrene of the extremities rank as precisely synonymous with Raynaud's phenomena? In this connection I will relate two cases. Both patients were healthy men. Their illness involved them in the loss of all the ends of the fingers, the tip of the nose and ears, and the ends of the toes. The drawing of the cases would lead one to suppose that there were black kid gloves thrown over the fingers. After the sloughing the men got quite well. In neither case has there been any disease subsequently. No renal disease or heart disease could be found to account for this local gangrene. No cause could be found. The history was that suddenly the extremities became painful, the limbs began to ache, next the aching was extreme. The patients were then put to bed. Severe illness followed, attended by symmetrical gangrene of the extremities. There was no evidence, I think, in these cases of susceptibility of the nervous system. A patient may be liable to asphyxiated extremities because that part of the nervous system which regulates the size of the arteries is very sus-

ceptible. When a cold impulse is transmitted through the hand to the nervous centres and the arteries are thrown into a condition of spasm, we may infer from the degree of irritation produced what tendency there is to local asphyxia and local syncope. If it goes to an extent which is morbid, then the slightest exposure to cold will induce either a reflex dilatation of the veins or a reflex contraction of the smaller arteries, and then the term under discussion becomes applicable.

What was the nature of their illness? You must keep in mind three or four different elements which may go into partnership in a case, one of which may gradually preponderate over the others.

First, we think of the vital endowments of the tissues, which differ in each individual. Next we pay regard to the arteries, which may be diseased or sound, small or large, or liable in a greater or less degree to be thrown into muscular spasm. Next we take into consideration the state of the nervous system and ask ourselves whether the reflex irritability of the muscular part of the arteries is morbidly irritable, and whether the nervous centres regulating the amount of the blood supply are in a state of irritability? Lastly, we have to consider the central organ of the circulation itself. The heart may be weak, very weak. If it were possible to depress the heart's action to that point at which it could only just carry on the circulation and keep the patient alive, we might explain the condition in which the blood could not get to the very ends of the fingers and toes; the extremities are manifestly at a disadvantage in being situated so far from the heart. So that is the hypothesis I would suggest in these two cases, namely, some serious unrecognised temporary condition of the heart, some inflammation of the heart substance. The fingers in both cases healed well. I make this suggestion with some diffidence, for I have no proof of its truth. The only other explanation I can offer is that the patients were liable to blood-poisoning also acting on the heart.

I always recommend students of medicine to study the diseases of the lower animals and plants, for in that study they will find some light thrown upon the problems of pathology in reference to the human subject. You see we can study the phenomena of acro-asphyxia, even see the point of death in plants under conditions in which we get rid of the nervous system and also of the centre organ of the circulation to some extent, though not wholly. The roots are the plant's substitute for the heart in reference to the circulation. The power in the extreme ends of the roots that helps to drive the sap upwards to the topmost buds, must be considered as somewhat similar to that by which the heart drives blood to the fingers. Every living thing must have a circulation. To prove that the rootlets do drive the fluid up, I may mention that you may cut across a birch tree three feet from the ground and leave not a single bud or leaf attached to it. Leave it standing during the winter, and in the spring you will see the once dry top of the tree beginning to pour out fluid, which will run down the sides in large quantity. So I assert that there is a *vis a tergo* which is generated by the roots below. As to what lessons the diseases of plants and trees may give us in reference to our interpretation of Raynaud's phenomena, you will see many examples of acro-sphacelus, *i. e.* the tips of the leaves are dead, the rest of the leaf being alive. Or in a lofty tree, perhaps, the very tops of the twigs are dead. Here, then, we have examples in which the extremities of a living thing will fall off owing to want of nutrition, caused by their distance from the *vis a tergo* to which I have just referred. The tissues and cells may have been attacked by cold, which

may have been sufficient to kill the ends of the branches, though not the whole of the tree. The tree, like the animal, is liable to be influenced by anything which enfeebles its roots. Thus, if a tree is dead at the ends of all its branches, while it is still producing a few leaves near the trunk, you may be almost certain that such a tree has something amiss with its roots. So I suggest as regards plants that they afford instances in proof that the peripheral parts of the tissues are more liable to be influenced by external cold, and they also show that the want of vigour in propulsion of the roots (equivalent to the heart in animals) may be the cause of their gangrene. Further, they illustrate disease of arteries; if the tracheides become blocked you will see that death ensues of the part of the bud. So in calcareous arteries; their calibre is diminished, and consequently the risk of acro-sphacelus of the part below is very much increased.

Now, a few words about the more common forms of the malady, in which we recognise Raynaud's phenomena. Not infrequently children of five years and onwards—not in young infants, for the nervous system is in them not sufficiently developed—we have a juvenile form. I might have mentioned chilblains on the extremities as one of the acro-sphacelous conditions, for they have an interesting relation to Raynaud's phenomena, although quite different. In chilblains there is local inflammation, which is absent in Raynaud's phenomena.

Children are more liable to chilblains than adults. Again, infants very rarely suffer from chilblains, because these have a good deal to do with the nervous system. The typical cases in children are of extreme asphyxia—blue hands, blue cheeks, the latter almost livid from the exposure. Typical cases of Raynaud's phenomena, sometimes running to gangrene, not merely of the extremities, but of the limbs themselves, may be induced, not by blood disorder, but through the influence of the nervous system. The juvenile form is liable to recur repeatedly in those who first become liable to it through the enfeebling influence of some illness.

There is another form which occurs in old people or those, at any rate, who have passed middle life. Here, not to the nervous system so much, but to the heart and the pulse you must pay attention. Ordinary senile gangrene must be thought of distinctly from Raynaud's phenomena, because it is scarcely ever symmetrical. From this we infer that local causes have to do with senile gangrene. The latter frequently results from some slight injury to an extremity in a person with diseased arteries.

Senile gangrene is, however, related to some forms of Raynaud's phenomena. If ever you see a case in which both extremities are infected, and in which the two hands in an old person are affected as well as the feet, you must investigate it on the lines on which you would investigate any other case of Raynaud's phenomena. As an illustration of such a case, I will mention that of an old man, *æt.* 80, whom I saw in the German Hospital of Great Yarmouth. The ends of *all* his fingers were in a state of gangrene. His arteries were so calcareous that I could scarcely feel the pulse. He had been in hospital several years before for what was considered ordinary senile gangrene in the big toe of one foot only. Otherwise he was in good health. There was no nervous element. What it was that produced the symmetrical attack in both hands and left the feet quite free was the problem. The attack occurred quite suddenly, not after any undue exposure. There was no obvious disease of the heart, but still I am inclined to think that the explanation lies in the progressive calcification of the arteries acting as a predisposing cause at first and then

becoming the determining factor, some slight unnoticed depressing influence of the heart being the final cause of the outbreak of the gangrene. Lastly, I have to mention another curious form with which I daresay some of you may be familiar. If not, ask in the skin department to be shown a good example of diffuse sclerosis of the skin or diffuse morphea. In this disease, the skin of the hands becomes stiff and hard; the fingers are stiffened and their ends look empty of blood; and the hands, when held up, look like badly-coloured pieces of tallow more than anything else, with patches of blood here and there. In this condition the hands are useless owing to the stiffness. This indurated condition of the skin will extend up the arm, according to the severity of the case, passing off very gradually. "Diffuse morphea" was formerly used to discriminate between this condition—not distributed by the nerves—and another form of morphea, in which the skin passes into the indurated state, as in herpes zoster or shingles, and is undoubtedly distributed by the influence of the nervous system. The digits of the lower extremities are less affected than those of the upper, and the face is affected. It nearly always occurs in women. It is impossible to pull up the skin of the face or of the hands, and this is a characteristic of the condition. The lips are hard and rigid, and the skin glossy and pitted over with little punctate vessels. You will thus gather that this diffuse scleroderma of the skin is a very definite condition, and easily recognised once you have seen it. The patient is liable to more or less paroxysmal change. But the hands are never well. After a time the bulbs of the fingers are all contracted and hardened, and little bits of gangrene occur close under the nails. Sometimes the whole end of a digit will become gangrenous. After ten or fifteen years a little improvement may take place as the result of treatment, but these cases never get absolutely well. Raynaud himself described some of these scleroderma cases in his first thesis, but they must not be confused with the others as they constitute a group quite apart. We must not, however, simplify too much and make classifications in the same way that we would classify plants and animals according to species. For pathological phenomena run into each other, and so we find relationships which we must recognise and not differentiate too arbitrarily.

I might say a word or two more about the senile form of Raynaud's malady. We expect to find structural organic diseases. I have one case of a man in good position who has never had a good circulation. He is 62, lives well, and has enjoyed good health. When he holds his hands up, they look painfully like those of a corpse, dead twenty-four hours. The bulbs of the fingers were dried and shrivelled, and there were little blue marks round the ends of the nails. His fingers were on the verge of going into gangrene. His pulse was rather feeble, and the question of calcareous arteries was doubtful. I refer to this case to mention a new symptom which I have recently observed in reference to these phenomena. The case also illustrates the importance of listening to what a patient has to tell you. He told me he had got a red mark in his nails. It was a little line exactly where the nail leaves its bed. It was very conspicuous and present in all his nails. The redness could not be removed by pressure. He had a condition of thrombosis of the capillaries at the very ends of the nails. I then looked at other portraits of cases with Raynaud's phenomena, and found (what I had overlooked) this red fringe accurately depicted. I ordered this patient to bed at once, and he has now been under treatment several months, and I hope he will escape actual gangrene.

*General Treatment.*—The first preliminary to all treatment and the advancement of therapeutics is to thoroughly understand all the causes of disease. It is no use for the most part acting in an empirical manner. If the nervous system is very susceptible in a reflex manner to the influence of cold, we must protect the patient from this cold. In the juvenile form we must insist on warm clothing, and if possible a warm climate. We want information as to international medicine and the influence of climate. Are these phenomena less prevalent in the Tropics? We know symmetrical gangrene occasionally occurs among the Hindoos. Would a young patient be benefited by living in the Tropics? I think so, and in private practice I recommend wintering in Egypt—a warm but not tropical country. If the case is one of sclerosis or morphea, the cause is less easy to assign, but the paroxysmal nature of the illness implies susceptibility to external cold to some degree. If he be an adult and cannot winter abroad, the best drug is opium—constant small doses (three or four drops of the tincture three or four times a day). If purgatives be given, then small quantities of opium do not agree. This should be given in combination with tonics, and careful attention should be paid to the liver. There should be also, I think, a moderate use of stimulants, but they should be given with very great care. Raynaud himself insisted in the later part of his life a great deal upon electricity. I have tried galvanism according to his methods, but I place my faith in the use of tonics, the maintenance of the external temperature, and the exhibition of small doses of opium over a long time—even years.

### Paris Clinical Lectures.

## THE HÆMODIAGNOSIS OF APPENDICITIS.

By Dr. TUFFIER,

Surgeon to the Paris Hospitals.

THE woman occupying No. 19 bed of the Jargavay Ward came under our care on account of an affection of which the clinical aspect is one of exceeding interest. It will be of advantage, I think, to discuss and classify her symptoms in the study whereof will convince you, a point upon which I have so often insisted, that clinical surgery ought, at the present day, to avail itself of laboratory research in the endeavour to make a certain diagnosis and thereby to arrive at the appropriate treatment.

The case is that of a dressmaker, 47 years of age, who, on April 4th last, came complaining of pain in the right iliac fossa and in the loin of the same side, also on account of a certain difficulty in walking.

Married at the age of eighteen this woman had a miscarriage a year later; she afterwards had two normal labours, one fifteen years ago, and the second three years after. In 1891, having gone up a ladder to reach a heavy parcel, she felt herself being forced backwards by the weight which she had lifted. To save herself from falling she bent herself sharply forwards, and immediately felt a sharp pain in the iliac fossa and right lumbar region, accompanied by the sensation of something having "given way." She was carried home, and almost at once a painful tumour appeared in the right side, visible on a cursory examination of the belly, and this was accompanied by some difficulty in passing water. Many surgeons, had they been consulted, would have diagnosed a "fibrous tumour," and suggested operation. This view having been disposed of, the patient was left at rest in bed with the head low. The swelling gradually diminished in size, the pain

subsided, and in about four months no trace remained of the lesion, the nature of which was obscure, but which we will endeavour to elucidate later on.

During the following ten years the patient enjoyed perfect health, and in the interval she bore a child.

The menopause occurred a year ago without giving rise to any trouble. At about this period, in July, she believed herself to have been poisoned by eating fish. She had lunched at 11.30 a.m., and at 2 p.m. she was suddenly seized with a feeling of discomfort and with flushes of heat and nausea, followed by copious vomiting and slight colic. She continued in this state till six o'clock in the evening. There was no distension of the abdomen, and no part of the belly was the seat of any particular pain. Five days' rest in bed and two purgations relieved these symptoms; the abdominal pain and digestive troubles disappearing for good.

In January the patient experienced vague discomfort, aching all over and pain in the legs, which was attributed to an attack of influenza. Lastly, on March 14th, feeling out of sorts, she took an aperient, and later in the day she experienced sharp pains in the right iliac fossa, running down the front of the thigh and along the crest of the ilium, of a shooting character and unaccompanied by either nausea or tympanites. The pains continuing, she was obliged to take to her bed; a physician having been called in, he treated her for "inflammation of the intestines," by milk diet and ice to the belly. From that day onwards the tendency to flexion of the thigh on the abdomen became more and more marked.

On April 4th the patient came into the hospital. Examination of the abdomen revealed neither tympanites nor any particular tumefaction in the iliac regions. There was no pain so long as she kept still. She only complained of pain, and even then not very acute, when the region of the iliac fossa, where all muscular resistance was absent, was deeply palpated. The examination furthermore showed us that the whole iliac fossa was filled by a mass of wooden hardness, rounded, projecting, with fairly well-marked outline, which appeared to extend from the ilio-umbilical line to the crural arch. This mass had a smooth surface, and was intimately connected with the bony framework of the region.

We also noticed, on the same side, a flexion of about 30° of the thigh on the pelvis. We were able to increase this flexion without causing pain in the hip-joint, which was evidently not involved. Extension of the limb was, however, impossible, and all endeavours to do so caused pain. I may add that examination of the uterus and its adnexa showed them to be normal. We did not discover any lesion of the vertebral column or of the pelvic bones. Questioning did not reveal any tuberculous or syphilitic taint in the antecedents of the patient.

Her general condition was good and her appetite was good. Nevertheless, the patient had lost flesh. The thermometer registered 37° 5 C. at night; twice only, during the week she was under observation, did it rise to 38° 2. Moreover, the temperature fell in the morning to about 37°. Within a few days, indeed, this woman became almost completely apyretic.

In the presence of these facts—tumour in the right iliac fossa, progressively increasing in size for the past eight months—a tumour which was hard and indolent and was closely connected with the iliac bone—what diagnosis were we to form? It was either a solid tumour of the pelvis, very probably a primary osteo-sarcoma, or a cold abscess occurring in the sheath of the psoas. If the latter diagnosis were the correct one it would still remain for us to decide what was the primary origin of the iliac abscess.

You may have remarked my hesitation one day in

favour of the idea of an osteosarcoma, the next inclining to the hypothesis of an abscess. The problem was far from simple. The bony hardness of the tumour, its rounded shape, its situation in the iliac fossa, of which it seemed to form part, its fixity, its indolence, and the age of the patient, all seemed to me to favour the idea of an osteosarcoma, especially as I did not see clearly what could be the possible origin of an abscess. Moreover there was not, in the immediate antecedents of the patient, any traumatism, either direct or indirect, which could account for the existence of an inflammation of the psoas. Neither could any general infection, typhoid fever, septic mischief, &c., be made to account for it. Nor, again, did there exist any neighbouring form of infection, osteomyelitis of the iliac bone or of the lumbar vertebræ, peri-appendicular abscess, suppurative peritonitis, perinephritis, &c., which, by extension, might explain suppuration within the sheath of the psoas. Now you are all aware that the three great factors of the production of psoas abscess are: traumatism, infectious pyogenic affections, and inflammation propagated by continuity or contiguity of surface. We were therefore justified in admitting the hypothesis of osteosarcoma of the pelvis, in spite of the occurrence of two febrile attacks; moreover, Verneuil has alluded to the frequency of fever during the evolution of the growth in question. This diagnosis was unanimously accepted by all my colleagues and by the candidates at the clinical examinations who examined the patient.

In spite of this I was haunted by the recollection of two very similar cases in which ordinary suppuration of the iliac fossa was mistaken for osteosarcoma. The first case especially was interesting. It was that of a woman, æt. 50, who had been seen by a number of surgeons, the diagnosis formed being unanimous, "a neoplasm of the iliac fossa." I was requested to attempt the extirpation of this tumour, and when I had incised the pelvic aponeurosis I came upon a collection of stinking pus. My second patient, whom I saw in conjunction with Dr. Selle, in 1897, was a man, æt. 60, suffering for several months past from pain, &c., in the right iliac fossa. The loss of flesh, the yellowish tint of the skin, the digestive troubles, characterised by alternations of diarrhoea and constipation, and also the presence of a tumour, quite wooden in consistence, indolent and nodular, forming part of the iliac bone, and the whole without any febrile reaction, inclined me to look for an adherent neoplasm of the cæcum. A few weeks later the constipation increased and symptoms of intestinal obstruction became evident, and an operation—having for object to establish an artificial anus—was performed. The seat of the neoplasm rendered it necessary for me to make an incision in the right iliac region. I found the aponeurosis slightly infiltrated by clear serum. I proceeded to investigate the nature of the tumour adhering at this point, for it appeared to me to be abnormal; I made an incision into it, and then I pushed in a grooved director, and suddenly I came upon a collection of stinking pus, whence issued a fæcal calculus. I had, in fact, opened up a peri-appendicular abscess. I drained the cavity, my patient recovered, and is still living.

The remembrance of these cases to the one under consideration reduced me to a singular state of perplexity. I feared to meet with a similar condition in this case.

It was in this frame of mind that I requested the Head of the Laboratory, Dr. Milian, to make an examination of the blood of this woman. I then awaited that light which might be thrown on the case by hæmatology before deciding on an operation.



The following is the note which was addressed to me by Dr. Milian on the very morning of the operation:—"Red globules 5,637,000 per cubic mm.; white globules 49,600, of which 75 per cent. were polynuclear, 25 per cent. mononuclear, and no eosinophiles. Too many white globules for a sarcoma, too many red globules for epithelioma; therefore it must be an abscess."

This diagnosis was amply confirmed by the operation, on April 10th, under analgesia produced by the intraspinal injection of 0 gr. 0.5 centigr. of cocaine. I made an incision about 10 centimetres in length very near to the right anterior superior iliac spine, in order to attack the tumour from its external surface. I was first of all struck by an œdematous infiltration of the subcutaneous cellular tissue and of the muscular wall, which was not less than 2.5 centimetres thick. Having arrived at the sub-peritoneal layer I found a hard, white, rounded, smooth mass, which I opened up gradually by the aid of a grooved director from the external surface to the inside without opening the peritoneum. This immediately gave exit to a considerable quantity of a thick, creamy, greenish pus of an extremely fœtid character. The finger, being inserted through the opening, penetrated into a cavity the size of an orange hollowed out in the surface and in the very thickness of the psoas muscle, the fibres of which could be felt. I inserted a drainage tube and a strand of sterilised gauze in the abscess cavity, and the dressing was complete. The operation had taken eleven minutes. The treatment after this was extremely simple. Every day the deep dressings were changed, and the walls of the abscess cavity flushed with oxygenated water. Two days after the operation the thigh could be completely extended, and the temperature fell to normal. The cavity is at the present time nearly dry, and the patient will leave the hospital completely cured.

The bacteriological examination showed, as is often the case with old-standing suppurations, the pus was poor in microbes. Only a few attenuated bacteria, whose exact nature has not been determined, were seen. They were apparently anaerobes, since the majority of fœtid abscesses contain this species of microbe.

What name ought we to apply to the lesions found? To what origin can we trace the psoas abscess?

An explanation might be found in the accident that occurred to the patient ten years ago. The tumour which appeared in the right iliac fossa, resulting from a sudden twisting of the body, might possibly be a hæmatoma consequent on rupture of the psoas, which became infected and suppurated when she was attacked by influenza in January. But the tumour had disappeared ten years previously, and all functional troubles had ceased, and it is not easy to admit the suppuration of a sanguineous collection which had remained latent and quiet for so long a time. It is more likely that the trouble which occurred last July, and which this woman put down to poisoning, was in reality an attack of appendicitis with the formation of a peri-appendicular abscess, which subsequently opened into the sheath of the psoas. The bacteriological examination of the pus only revealed the existence of a common species of microbe; but you must bear in mind its fœtidity, which reminded us of suppurations of intestinal origin.

In any case it is not these retrospective considerations which constitute the interest of this case, and I should not have discussed the diagnosis at such length if it had not afforded me an opportunity of demonstrating the utility of laboratory methods and the spirit in which they ought to be pursued.

You recollect the hæmatological note which I

read to you, the rather laconic ending of which was "too many white globules for a sarcoma, too many red globules for epithelioma, therefore it must be a collection of pus." You are naturally convinced of the correctness of this deduction since you assisted at the evacuation of the abscess, but you have not, perhaps, exactly grasped the salient features.

It was Professor Hayem who first insisted on the necessity of examining the blood of patients suffering from disease and who showed what help this gives to diagnosis. His work on the blood, which already dates from 1889, foretold the numerous discoveries which have since arisen therefrom. "The future belongs to hæmatology," he wrote, "this it is which will solve those great nosological problems." It is astonishing that an attempt was not made in this direction sooner since doctors were urged in this direction by popular belief; to the ordinary person even at the present day it is the changes in the blood, "corrupted blood, turned blood," the "nerves stronger than the blood, &c.," which are at the root of every morbid condition. It is, thanks to this belief, that you never experience any reluctance on the part of the patient to have his finger punctured to draw blood, for he is profoundly convinced that therein lies the key to all the pathological mysteries.

What are the changes which occur in the blood during an illness? They may be chemical, physical, or histological. We will put aside the first two since they are but little known. Not so it is with the histological changes since, thanks to the energy taken during the last few years in the study of the figurative elements of blood, they commence to be well understood. The red globules, the white globules (polynuclear, mononuclear, eosinophiles) undergo in the course of disease variations in their formula and in their equilibrium which may guide us to the affection which causes them.

In a general way the "injections" give rise to an increase in the proportion of white globules, leucocytosis, which increases the number of leucocytes to 20,000, 30,000, and even 50,000 per cubic millimetre, the ordinary proportion being from 6,000 to 8,000. Leucocytosis, above all, affects the polynuclear elements. This formula is especially true in connection with the acute suppurations which interest surgeons.

The tumours, epithelioma at least, are also accompanied by polynuclear leucocytosis. This is a fact which M. Hayem proved a long while ago, and certain latent varieties of cancer of the stomach may thus be revealed. But that which makes us think rather of cancer than of suppuration, is the anæmia which accompanies this leucocytosis (Hayem). This anæmia, in addition to the clinical phenomena with which you are familiar, manifests itself hæmatologically either by a diminution in the number of red corpuscles or by a diminution of the blood in hæmoglobin, globular richness as it is called, or by both at the same time. We have thus means of discovering the anæmia and therefore the cancer.

Till lately no attempt has been made to differentiate between epitheliomatous and sarcomatous tumours. Now, it would seem, from the researches of M. Milian, which were laid before the Anatomical Society two months ago, that it is not impossible to do so. Sarcoma, at least globo-cellular sarcoma, does not generally give rise to leucocytosis, and, above all, not to anæmia. On the contrary, as regards the red corpuscles the few elements found point to hyperglobulia, the proportion of red corpuscles may even attain to from six to seven millions per cubic millimetre instead of the normal proportion of five millions. Besides, you must have noticed that patients suffering from sarcoma, and who have not reached the period of cachexia are not pale, nor are the mucous membranes discoloured.

From this explanation, a little diagrammatic it is true, but conforming nearly enough to the reality, you will understand the following: "Too many white globules for sarcoma, too many red corpuscles for epithelioma, therefore it must be a collection of pus."

The hæmatological researches are few in connection with appendicitis. It was recently claimed that eosinophilia was a symptom of appendicitis. My own experience was not in favour of this view; we had the polynucleosis (75 per cent. of polynuclear cells instead of 60 per cent.), but we did not count a single eosinophile cell in our percentage, while a healthy subject possesses one or two leucocytes per 100 of this variety. In infections the eosinophile cell is much more affected by the resistance of the organism and the disappearance of the infectious process than by the nature of the illness, this being the outcome of a communication made last May by MM. Løper and Milian before the Anatomical Society. Eosinophilia occurs at the termination of infectious states, in subsident appendicitis on each occasion, in other words, in which the organism comes out of its struggle victorious." The blister test, of which MM. Roger and Josué have recently shown the utility in view of the prognosis, is in favour of this explanation, since in healthy subjects or in those who vigorously resist injection, the eosinophile cells constitute 25 per cent. of cells of the blister fluid. Eosinophilia is produced in affections due to animal parasites (Milian); you may remember in connection with this subject the man with hydatid cyst of the lung on whom I operated under spinal anæsthesia, and of whom I show you photographs taken during the operation. The examination of the blood made beforehand revealed 5 per cent. of eosinophile cells.

You will see therefore that the increase in the number of eosinophile cells cannot be of any use to us in forming a diagnosis of appendicitis, quite the contrary, since there still remain temporisers, partisans of the ice-opium treatment without purgatives who might perhaps seek in this reaction of the blood indications of cases in which an operation should not be performed.

With regard to appendicitis accompanied by an abscess similar to the one we have just been dealing with, hæmodiagnosis furnishes us with a means of detecting it not by the existence of eosinophilia but by the "inflammatory reaction" of the blood, of which the polynucleosis is the most important element, and which is found in cases of infection or suppurative collections.

I hope you will profit by this lesson, and that you are convinced of the utility of these researches, so often neglected in surgery. You see them pursued daily in my wards, and you are aware of the help they afford us. Never, therefore, neglect hæmodiagnosis or cystodiagnosis when you think they are likely to afford you a clue to the affection; these are methods which ought at the present day to replace exploratory laparotomy, or at least to considerably reduce the necessity for it.

## SOME PRACTICAL MODERN ASPECTS OF GOUT AND GOUTINESS.

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THE close connection between gout and certain skin affections is a well-recognised fact in practical medicine. The important bearing of such knowledge upon prognosis and treatment quickly becomes evident to any physician paying special attention to

diseases of the skin. It is only by slow degrees, however, that he learns to fathom the mysteries of irregular gout in relation to various cutaneous troubles.

As everyone knows, the malady of gout has attracted the attention of physicians since the earliest dawn of medicine. It has furnished a group of signs and symptoms so well marked and so striking as to have stimulated the curiosity of all ages of scientific mankind. Nothing could be more graphic than some of the classical descriptions of a "fit of the gout," which presented the same features to Galen, or to Boerhaave and Sydenham, as it does to the practitioner of to-day. For all that, much of the inner history of gout remains to be written.

The great modern theory ascribing gout to the presence of uric acid in the blood was advanced by Forbes and others towards the end of the eighteenth century. (a) That theory has since held the field through many vicissitudes. Its greatest confirmation was the demonstration by Garrod of uric acid in the blood of gouty patients. A definite basis was thus furnished to the proposition that gout was due to a chemical poison circulating in the blood. From that point, however, the thread of investigation appears to have been lost, and we find ourselves faced with a host of conflicting theories as to the origin and the exact part played by uric acid in the gouty state.

The origin of the uric acid, for instance, is in dispute, whether it is the product of tissue changes or of the decomposition of, so to speak, wout-producing food introduced into the body. Although uric acid is formed in the blood of gouty patients its presence has not yet been satisfactorily demonstrated in the blood of healthy individuals. That it must be manufactured somewhere in the body is clear, inasmuch as in small amounts it is a normal constituent of human urine. The most rational inference appears to be that the uric acid is formed in the kidney, at any rate while it remains within physiological limits. The ratio of uric acid to urea is inconstant, but that fact does not prevent some physicians from attaching great importance to the ratio as revealed by analysis.

The theory of the renal origin of gout is attractive, and may be stated shortly as follows. When for some reason or other the kidneys fail to excrete uric acid it is thrown back into the circulation, where it exists, at first as a soluble quadrinate of sodium, but later saturation of the blood leads to the formation of an insoluble biurate, which is deposited in the tissues and sets up characteristic acute and chronic local changes. This view was first advanced by Bence-Jones and Roberts on the strength of chemical experimentation. It has lately been disputed by Drs. Tunnicliffe and Rosenheim, (b) who say there is no evidence as to the existence of quadriurates either in the amorphous urinary deposits or in the fluids of the body. Short of chemical proof of the intermediate combinations, the presence of uric acid in the blood and of the specific uratic deposits in the tissues may be regarded as established gouty phenomena.

The theory of the renal origin of gout is supported by the frequent association of kidney disease and gout with lead poisoning. Here the order of circumstances might readily be, first, a kidney damaged by lead; secondly, a damming up of uric acid in the blood, with consequent gout; thirdly, the granular kidney so constantly associated with chronic gout, due partly to the lead and partly to irritant gouty material.

Substitute for lead any other blood-borne irritant that would check the excretory function of the

(a) "Treatise upon Gravel and Gout," Forbes. 1793.  
(b) *Lancet*, June 16th, 1900.

kidneys, and we at once find a great variety of chemical and bacterial irritants that might be concerned in the production of gout. In the year 1890 (a) the present writer pointed out how the general irritation of excretory organs occurred during the elimination of the gouty and other irritants from the body. This general law of excretory irritation (b) explains the action of irritants such as metallic poisons, drugs, and specific micro-organisms and their products circulating in the blood. In the case of gout it gives a key to the eczema, dyspepsia, diarrhoea, bronchitis, and kidney troubles associated with that disease both in its regular and irregular forms.

The attempt to settle the pathology of gout in the chemists' laboratory, then, has not hitherto been conspicuously successful. The physician must therefore fall back upon such facts as he can gather from his own observation. He may conveniently divide the symptoms of gout into two groups: first, that due to uratic deposits in the tissues of joints and other internal structures; and, secondly, that in which skin, mucous membrane, kidneys, and other excretory organs are irritated by the elimination, or attempted elimination, of some toxic substance connected with gout. The second group includes the two arbitrary forms, visceral and cutaneous, into which not a few writers still divide the manifestations of irregular gout.

#### DIAGNOSIS.

Gout in its typical form is sharply marked off from other diseases. There is no need to detail its hereditary nature and proneness to attack males between thirty and forty years of age; its painful nocturnal onset of acute articular and periarticular inflammation with uratic deposits, at first monarticular and usually in the great toe; its tendency to recur again and again, and in time to deform and cripple progressively; its choice of the well-to-do and full-blooded; and its association with bronchitis, asthma, eczema, dyspepsia, neuritis, gravel, kidney disease, hæmorrhoids, varicose veins, and other symptomatic and degenerative troubles.

Irregular gout is less readily distinguished, but can usually be diagnosed by a careful consideration of the facts of the case.

Rheumatism, on the other hand, is prone to attack young persons; it attacks the larger joints, and, if acute, is attended with high temperature and acid sweats. In all forms the heart is extremely liable to be affected, and the arthritis is of a shifting nature, rarely involving the entire destruction of a joint. There is no deposit of urates in the joints or elsewhere. The modern view is distinctly in favour of a specific micro-organism in rheumatism.

Rheumatoid or osteo-arthritis (or "rheumatic gout"), may also be possibly connected with a specific microbe. It may be confused at times with chronic gout, although in most cases a close examination will serve to distinguish the two conditions. In polyarticular rheumatoid arthritis many joints are successively involved, and the disease progresses steadily onward until the joint is disorganised; there are not the acute recurrent attacks and the remissions of gout, neither is there any deposit of urates. It is true that the rheumatoid condition may gradually supervene in joints affected with chronic gout, or that gouty deposits may take place in joints that have long been the seat of rheumatoid changes. A clear survey of all the circumstances of the case, however, including the family and personal history of the patient and of his complaint will generally furnish ground for a diagnosis. It should be borne in mind that rheumatoid arthritis is the result of poor living and depressing influences.

In all chronic arthritic complaints a mere inspection of a joint may fail to reveal the nature of the disease, which can often be ascertained only by the most careful and skilled investigation.

#### TREATMENT.

The treatment of gout may be conveniently discussed under the three headings:—

1. Drugs.
2. General hygiene; exercise, diet, water, &c.
3. Baths, massage, superheated air, and other external therapeutics.

1. *Drugs.*—The most valuable drug during an acute attack of gout is undoubtedly colchicum, which has so far been replaced by no product of the chemists' laboratory. It is usually combined with sulphate of magnesia, and its efficacy appears to be increased by the addition of guaiacum. Free purging with blue pill and saline aperients, such as Hunyadi Janos, or other laxatives, is an essential measure. The acute pain in the joints may be relieved by warm alkaline fomentations or by the "A.B.C." liniment (aconite, belladonna, and chloroform) sprinkled on lint and applied to the joint under oil silk.

Between the attacks of acute gout, and in the chronic and irregular states, the best drugs are sodium salicylate, iodide of potassium, and guaiacum. Of those remedies the two first-mentioned appear to increase the excretion of uric acid by stimulating the activity of the kidneys. Their good effect certainly does not result from their solvent action upon biurate of sodium deposits; nor, in spite of theoretical chemistry, is that solvent action exercised in the body, at any rate to any considerable extent, by lithium, piperazin, lysidin, and other much lauded uric acid solvents. At the same time those drugs no doubt have a valuable place in treatment.

2. *General Hygiene.*—This forms one of the most important points in the treatment of the gouty. The patient should take daily exercise, as far as possible in the open air. Golfing, cycling, tennis, bowls, riding, and shooting are all excellent, while indoors billiards offer a good excuse for sustained moderate activity. There is no need to remark that a man who lives an active life can eat and drink with safety a good deal more than one who is lazy and inactive. From the nature of his surroundings the average town dweller combines a minimum of exertion with a full allowance of food and drink. It naturally follows that he is not able to use the fuel wherewith fashion and habit have led him to feed his bodily engine. Fortunately, it is still open to him to some extent to restore the balance of input and output by regulating the supply of fuel, both as to quantity and quality. The more one knows of modern social habits the stronger grows the conviction that the chief error lies in quantity rather than in quality. It is not the one glass of champagne or of port that does the harm, but the three or four glasses or the bottle. Neither is it the occasional excess that works the mischief, but rather the constancy and the frequency of the indulgence. Many a man who has damaged his liver and kidneys by drinking at and between meals would indignantly resent the suggestion that he was anything but a temperate man. As with drinking so with eating. It is not the quality of the food so much as the quantity that does the harm. Three heavy meals a day is the rule rather than the exception with the well-to-do nowadays. Meat is taken on each occasion, to say nothing of other dishes, and of a formidable array of wines, liqueurs, and other alcoholic stimulants. So far as the gouty are concerned, the present writer is inclined to the view that the sufferer if enfeebled is all the better for a glass of sound wine at meal times. The quality must be good, and the quantity be kept rigidly within the limit of a single glass. The permissible wine

(a) MEDICAL PRESS AND CIRCULAR, October 22nd, 1890.  
"Excretory Irritation." London: Baillière. 1897.

would be, say, sound dry sherry or claret at luncheon, and champagne or light port well-matured in the wood at dinner; with perhaps a "night-cap" of mellow Scotch whisky, well-diluted with Kronenquelle, seltzer, or other pure plain or aerated water. Malt liquors should not be allowed under any circumstances.

It should be clearly understood that although alcohol, under the foregoing precautions, may be allowed to gouty patients, yet on the whole it is likely that unless they are suffering from marked debility they would be better without alcoholic beverages. The main difficulty is often a social one, for it wants some courage for the average man to ask for plain or aerated water when a guest, say, at a friend's house or at a public dinner, or even when dining at his own expense at an hotel or restaurant. Yet water is beyond a doubt the best thing for a gouty man to drink under ordinary circumstances. Perhaps one of the surest advances hitherto made in the treatment of gout was the discovery of the solvent action of water upon uric acid. There can be little doubt that as a rule we do not drink enough water. Moreover, what we citizens drink is as a rule hard water, the influence of which upon the human constitution has never been scientifically gauged. The Londoner drinks water that is heavily charged with earthy matter, inasmuch as it contains no less than fifteen grains to the gallon of lime and magnesia salts or their equivalents. (a)

The influence of water with a high degree of permanent hardness upon the health of the consumer is definitely shown in some cases by dyspepsia and diarrhoea. Another malady that appears to be related to the quality of drinking water is goitre, but the subject requires further research. The opinion was at one time commonly held that hard water was concerned in the production of urinary calculi and gravel, but lately it has fallen more or less out of sight in the absence of definite proof. On the whole it may be said that while there is no positive evidence to connect hard drinking water with gout and gravel, yet, on the other hand, there is nothing to exculpate it from the charge. The daily intake of a large amount of lime and magnesia salts into the system must throw an unnecessary stress upon the kidney by way of subsequent elimination. In that way, if in no other, hard water may possibly contribute indirectly to the causation of gout. Atheroma of blood vessels, again, is common in advanced gout, and it is worthy of consideration whether that form of calcareous degeneration may not possibly be connected with the constant drinking of water heavily charged with lime salts. At any rate, gouty people cannot afford to take unnecessary risks, and the best drink for them is di-tilled water, plain or aerated, but it should be borne in mind that many of the aerated waters are made from ordinary hard drinking water. In many cases a mild alkaline natural spring water is the safest and best water for habitual use by the sufferer from regular or irregular gout.

The quantity of water consumed needs regulation as well as the quality. To drink a tumblerful of water fasting in the morning is good for almost anyone, gouty or not gouty. A copious draught of water under these circumstances flushes the kidneys and assists the action of the bowels and skin. To drink tumblerful after tumblerful of water, however, at intervals throughout the day is to spoil a good thing by carrying it to excess, especially when the debauch of water is combined with low diet. A full-blooded patient placed under this system would no doubt benefit up to a point, but after that he would be more likely to down hill than to recover.

Chronic gout, it cannot be too strongly insisted upon, is a disease marked in its advanced stages by debility. Such a patient requires nutritious diet, together with, in some few cases, a moderate amount of alcoholic stimulation, while all lowering measures should be adopted with caution.

The choice of a good water, then, may not improbably exert a considerably influence in the treatment of gout. It has long been accepted as a maxim that no combination of drugs can produce the medicinal effects of a natural mineral water, and some continental physicians claim excellent results from the use of Kronenquelle by the gouty. That particular water is mildly alkaline, and contains sodium, magnesium, calcium, lithium, and other bicarbonates, sodium sulphate, a small quantity of sodium chloride, with traces of iron and other salts. It has been shown by Fürst that bicarbonate of sodium, when well diluted, is a solvent of uric acid, and that the bicarbonate of calcium, which in 1 per cent. solution does not dissolve uric acid, when reduced to a strength of 5 per mille or 5 per cent., becomes almost as powerful a solvent of uric acid as the carbonate of lithium. This striking observation suggests a possible explanation of the good results reported from the use of Kronenquelle water in the uric acid diathesis.

3. *Baths*, superheated air, and other external therapeutics.

The value of the Turkish bath has long been recognised in the treatment of the gouty condition. So also has the value of a course of systematic bathing and massage at some suitable spa, where the life is simple and plain. But with Turkish baths and with spas the experience has generally been that though they often alleviate they do not cure the malady. What physician is not familiar with the story of the gouty patient who has gone in vain from spa to spa and has tried in vain drugs, massage, electricity, baths of every kind, water cures, and all other recognised or unrecognised methods in the pursuit of health?

The therapeutics of gout, however, have made a solid advance in the shape of the Tallerman superheated air treatment, invented in England some ten years ago. As most people know, one part of the body, say, an arm or a leg, is subjected to a temperature of between 200° and 300°. Copious sweating follows and analysis shows that the quantity of uric acid excreted by the kidneys is greatly increased under ordinary circumstances. The extraordinary results that often attend the application of the Tallerman treatment in cases of acute or chronic gout must be seen to be believed. In one instance under the notice of the present writer a stockbroker was treated for an incipient attack of gout, from which he often suffered. The toe was red, shiny, and painful when put in the apparatus, but on the following day he was able to join a shooting party. That result will speak volumes to all who are acquainted with the ways of acute gout. In chronic and in inveterate cases the benefit is striking: movements of joints are restored and uratic deposits and bursal swellings often disappear rapidly.

There can be no doubt that heat applied according to the Tallerman method has curative results in gout that cannot be equalled or even approached by other plans of treatment.

That a patient undergoing the superheated air treatment will derive benefit from a combined course of medical treatment need hardly be added. The use of Kronenquelle water, for instance, will always be of service. Sometimes drugs will be needed, and in all cases careful attention must be paid to details of general environment of the patient. The physician, indeed, will find it necessary to investigate every detail of the case before him, and to study th

(a) Parkes and Kenwood "Hygiene," p. 13.

peculiarities of his patient to a greater extent in gout than in most of the maladies that he is called upon to deal with in his consulting-room. The most careful and conscientious attention of the physician, however, will avail little without the utmost obedience and self-control on the part of his patient.

## LOWER BIRTH-RATES CONSIDERED AS THE REAL CAUSE OF LOWER DEATH-RATES. (a)

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THIRTY years ago, and for many years previous to 1877, the main effort of sanitarians was directed towards the improvement of water supplies, drainage, and cleansing of cities and villages. Sir Edwin Chadwick and Sir Benjamin Ward Richardson were most ardent sanitarians, and I had often the opportunity of hearing their views as to the possibility of reducing the death-rate of our cities by the rigid carrying out of such methods of cleansing and removal of all filth. Being rather sceptical on this point, I ventured to remark that as long as people are very poor, death-rates will remain high, cleanse as you will. Well, the following figures taken from the Registrar-General's Report for the year 1877 seem fully to bear out my contention. On page lxxxvi. of that Report, I find that the mean rate of mortality in London for the 38 years between 1840 and 1877 was 24 per 1,000 inhabitants annually. Now this was just the epoch in which distinguished sanitarians like Sir Edwin Chadwick had accomplished so much in improving the drainage of London, and the cleansing of its houses and streets. But, up to 1877, the effects of all these excellent endeavours had been nugatory, as regards the main aim of hygienists, viz., the lowering of the death-rate. Since 1877, however, the birth-rate in London and in almost all our cities has fallen considerably. The birth-rate in 1877 in England and Wales was 36.2, and it has fallen in 1900 to 28.5 per 1,000 inhabitants. This fall in the birth-rate has been seen to occur in all civilised countries since 1877, and is universally attributed by enlightened statisticians, such as Dr. Billings, of the United States Registry Office, to the voluntary lessening of the number of children to a family. This lower birth-rate is due to the discussions on the population question which took place in 1877 when Mr. Charles Bradlaugh, M.P., and Mrs. Annie Besant were prosecuted for the publication of Dr. Knowlton's pamphlet on this subject. Immediately on the birth-rate falling there occurred a similar fall in the death-rate, and last year the death-rate in England and Wales had fallen from 20.4 per 1,000, its figures in 1877 to 18 per 1,000. The meaning of this is that the human race could, if amply supplied with food, double its population in much less than twenty years, so that the more thoughtless and indigent classes are constantly being cut off by the want of sufficient wholesome food, and by over-crowding, which favours the spread of fevers and tuberculous diseases. I have mentioned that the birth-rate has fallen in almost all civilised states since the year 1877. The most notable example of this statement is to be found in the case of our beautiful and flourishing colony of New Zealand.

The birth-rate in 1880 in New Zealand was 40.78 per 1,000 inhabitants, and has fallen, owing to the same cause which has lowered it here, i.e., parental

prudence, to 25 per 1,000 in 1900. The death-rate, however, in modern New Zealand is given at 9.1 per 1,000 in 1896, so that the colony may be said to have reached the zenith of hygienic existence. The death-rate, we see, is only one-half that of the death-rate of England and Wales. The actual number of deaths registered in 1887 was 6,137, with a mean population of 596,374 that year, and in 1896 the population was 706,846, or 110,472 persons more than in 1887, and yet there were only 295 more births in 1896 than in 1887. The marriages, however, show a remarkable increase in New Zealand. In 1887 there were 5.97 marriages per 1,000 inhabitants, and in 1896 there were 6.85 per 1,000. Hence the lowering of the birth-rate in New Zealand has caused an extremely low death-rate, and a much higher marriage-rate. Obviously we in Europe have much to learn from the modern inhabitants of that colony.

In a paper read before the Medical Society of London in 1879, on the "Mortality of the Rich and Poor," I cited, first of all to show that poverty was the main cause of premature death, the paper of Dr. Villermé, of Paris, in 1834, which showed that between the ages of 40 and 45 the death-rate of persons in easy circumstances in Paris was 8.3 per 1,000, whilst among the poor the figure was 18.7, i.e., 2½ times as high among the poor as among the rich. Sir Edwin Chadwick, in a pamphlet which he gave to me at Paris in 1877, "On the Dwellings of the Wage Classes," mentioned that it was misleading to cite the death-rate of a whole city, since there were sub-districts in London where the death-rate does not exceed 11 per 1,000, whilst there are adjacent dwellings where the death-rate rises in some years to 38 per 1,000 inhabitants. That able statistician in 1843 made an inquiry in Bethnal Green, when the general death-rate of London was 24 per 1,000. From this it resulted that in Bethnal Green the gentry, professionals, and their families showed a proportion of 6.5 per cent. of deaths from zymotics to total deaths; whilst the figure for the labourers and their families was 22.2 per cent. of all deaths occurring among that class; there was 1 death in 10 among the children of the former class in the first year of life, and 1 in 4 among the latter; 24.7 deaths per cent. occurred among children of the richer class under 10 years of age, against 54.5 among the poorer. The mean age at death of all dying among the well-to-do was 44, and only 22 among the poor. Lastly, the mean age at death of all after the age of 21 was 61 among the well-to-do and 49 among the labouring population.

These statistics of Sir E. Chadwick are quite sufficient to prove that the mortality of the wage classes is far higher than that of the well-to-do classes. And we know that the birth-rate of the poorer classes is often double that of the rich, which explains my contention that to lower death-rates we must lower birth-rates, or give up the attempt to improve the public health in despair, since, do what we will, low wages and large families are always in Europe followed by high death-rates.

Perhaps the most telling of all statistical inquiries on this point is the one made by Mr. Charles Ansell, jun., Actuary of the National Assurance Company, published in 1874, entitled, "Statistics of Families of the Upper and Professional Classes (England and Wales)."

The Report referred to 48,044 children of these classes and Ansell found that among these children the death-rate in the first year of life was 80.45 per 1,000; whilst we know that in some cities, such as Preston, the infantile death-rate sometimes exceeds 400 per 1,000. Again, among the children of the richer classes Ansell found the death-rate between the ages of 1 and 5 was 47, against 113 among the general population. He found the mean age at

(a) Paper taken as read at the Cheltenham Meeting of the British Medical Association in 1901.

death among the well-to-do classes to be 55 years, and that 80,000 out of 100,000 born survived to the age of 21, against 65,700 among the general population. One statement made by Mr. Ansell in his Report was very striking. It seems that in the year 1873, 368,179 persons died in England and Wales under the age of 60 and he calculated that had the general mortality been only as low as that of the well-to-do classes, only 226,040 would have died. So that, in one year, that of 1873, poverty destroyed 142,130 lives in England and Wales alone. Our great philosopher, Professor Alexander Bain, has summed up the question as follows:—"That prime requisite of happiness, health, is very imperfectly secured in the lowest grades even of respectable citizenship. The public registers have demonstrated that mortality and disease diminish with every rise in the scale of wealth." The obvious inference from this is that hygienists must study the science of wealth, *i.e.*, political economy.

A great deal of interesting information has been acquired concerning the influence of various trades and occupations on health; but it has been truly remarked by Dr. D'Espine, in the *Annales d'Hygiene*, that the so-called mortality of several trades is only another name for poverty (since well-to-do people will not expose themselves to such dangerous occupations). Dr. Thouvenin, too, in an article on the "Influence of Trades on Health," arrives at the conclusion that, with the exception of cotton-beating, dividing and carding of silk cocoons, white lead grinding, and one or two others, industrial pursuits do not exercise any directly injurious effects on the health of the workers. He traces the deterioration of the health of the wage classes in towns, and their higher death-rate to defects in their dwellings, to hereditary and skin diseases, to venereal and tuberculous diseases, to the excess of their premature labours, and the scanty nature and bad quality of their diet, the irregularity of their lives whilst still immature, and lastly, to drunkenness. The summary of these causes is but another way of naming poverty, and D'Espine showed that which my own experience as physician to the North London Consumption Hospital has shown me, that whilst tuberculous disease forms 68 per 1,000 of all deaths among the well-to-do classes, no less than 230 per 1,000 of the poor die of tuberculosis per 1,000 of all their deaths. Rickets, too, are lamentably frequent among the poor children of London, Manchester, Glasgow, and even in our villages from the poor nutrition of such children. The late Dr. Edward Smith found that the parents of the patients coming before him as consumptives had given birth on an average to 7.5 children to each family, whilst Dr. Lutaud, of Paris, in a letter to Hr. Hausmeister, mentions that the wives of 100 medical practitioners in Paris give birth to only 150 children, *i.e.*, to 1.5 children per family. It is easy to see that the children of persons with low wages and large families are doomed to be ill-fed, and thus ready to contract that terrible scourge tuberculosis.

In the year 1898 the Board of Physicians of Hamburg published the following statistics as to the connection between income and infantile mortality. In 1898 21,399 living children were born in Hamburg, of whom 4,033 died in their first year of life. Of these, 1,784 died of mal-nutrition. A comparison between the several districts of the city showed:—

Quarter of the town.	Average income per head in marks. 1 mark = 1 shilling.	Mortality of infants per 1,000 inhabitants.
Harvesthude ...	2,829 = £141	2.02
Rotherbaum ...	2,150 —	2.47
Alstadt Sud ...	658 —	3.63
Newstadt Sud ...	353 —	9.39
Horn ...	295 = £15	10.85
Belwarder Ausschlag ...	266 —	9.00

Thus, in the poor quarter of Hamburg (Horn) the infantile mortality is five times that of the rich quarter (Harvesthude). So that wealth is the main factor in producing longevity for the masses.

The statistics of London (as appearing in the *British Medical Journal*) for the year 1899 show the same facts. Thus, the birth-rate of a well-to-do district, Hampstead, was 19.8, and its death-rate was 11.6, whilst the poor district of St. Luke's had a birth-rate of 44.4 and death-rate of 28.4 per 1,000 inhabitants in 1899. Some years ago the late Mr. Ernest Hart, at my suggestion, had a column headed "Deaths from Phthisis added to the Statistical Table of London"; and this showed that the death-rate from phthisis in well-to-do Hampstead was only 0.8 per 1,000, whilst in St. Luke's the figure was 3 per 1,000 inhabitants, or more than thrice as high as in Hampstead.

It seems to me that these few statistics, which I could multiply to any extent, prove clearly that the death-rate of the poorer classes is very much higher than that of the richer, and also that their birth-rate is usually twice, or even thrice, as high. Hence I think I am entitled to say that I have shown that the main cause of high death-rates in this country is high birth-rates; and that if we wish really to improve the health of the classes at the bottom of society, we must endeavour to persuade them to have families of not more than four children as a maximum; and better still, to content themselves with even fewer than this, until the mortality of the worst-paid classes shall fall to 12 or 13 per 1,000, which is now the rate among the inhabitants of Hampstead and some of our richer towns.

## Transactions of Societies.

### CLINICAL SOCIETY OF LONDON.

MEETING HELD FRIDAY, OCTOBER 11TH, 1901.

MR. ARTHUR BARKER, F.R.C.S., Vice-President in the Chair.

THE PRESIDENT presented the new volume of the *Transactions*, remarking that surplus copies could be obtained by members at a reduced price.

MR. J. JACKSON CLARKE read notes of a case of

PAINFUL CONDITION OF THE TWELFTH PAIR OF RIBS.  
The patient was a nursemaid. She first came for treatment on account of a forward bend of the spine (kyphosis) accompanied by a painful backward projection of the tips of both twelfth ribs. The former was corrected by the use of an antero-posterior support, but the condition of the twelfth ribs remained unchanged, any forward pressure upon them causing great distress. The pain was deeply seated, and Mr. Clarke referred the abnormal condition to rheumatoid inflammation of the costo-vertebral joints. So long as the spinal support was worn it sufficiently protected the ribs from pressure; when, however, the time came for leaving off the support the patient found that she could not bear the pressure of her dress upon the ribs. An attempt was made to palliate the condition by making apertures in the patient's stays, but this did not succeed. The patient was therefore advised to undergo an operation for the removal of as much of each twelfth rib as could be taken away without incising the erector spinae. The operation consisted of cutting down on each bone in turn and removing one inch, including the cap of cartilage, with the periosteum. The deep parts were carefully drawn together by fine silk sutures before the skin-wounds were closed. Rapid healing ensued. There was no subsequent bulging at the site of the operations, and the pain was at once relieved and has not since returned. Mr. Clarke mentioned another case in which one of the twelfth ribs was the seat of occasional swelling, accompanied by great pain. The patient was a lady, *æt.* 40, and the swelling

was due to inflammation about the junction of the cartilage and bone. In this case relief was obtained by an abdominal belt made with a recess to receive the tip of the rib.

Dr. EWART referred in connection with this case to a condition known as *acrochondralgia*, a strictly localised condition due to a variety of causes. It was aggravated by the pressure of corsets unless one of the ribs thereof was broken through. He expressed surprise at hearing that osteo-arthritis of the joint was relieved by the removal of a distal fragment of bone, and he asked what length of rib was excised. He also asked what evidence there was of the existence of osteo-arthritis.

Mr. CLARKE, in reply, did not think that tight-lacing had anything to do with the production of the condition in his case. He thought that it was probably due to the action of the muscles on a weakened articulation. He took away about half an inch. The cases referred to by Dr. Ewart were interesting, but were not parallel. He referred to the case of a lady, *æt.* 40, who had acute pain in the tenth rib, which, when first seen, in the interval of the attacks, presented nothing abnormal, but later, during an attack, he found a swelling at the end of the rib the size of a filbert. The pain was relieved by a suitable support.

#### CASE OF DISPLACED STRANGULATED FEMORAL HERNIA.

Mr. THOMAS BRYANT read notes of a case brought on April 3rd, 1901, by Dr. Robinson, of Wandsworth Common, into Bolingbroke Hospital. She was a married woman, *æt.* 32, who had been troubled with a femoral rupture for about five years and had not worn a truss. The rupture had come down every now and then, and she said she had never experienced difficulty in its reduction, although on questioning her husband later on he was sure that she had often used much force in reducing the rupture, and particularly on March 29th, two days before her present illness and the attendance of Dr. Robinson. Her illness was supposed to date from March 31st, and it commenced as a "bilious attack," to which she was rather prone by sickness and headache, and it was not till three days passed, and the vomited matter had become stercoraceous, that the possibility of the case being due to her reduced hernia had been realised and my advice was sought. When he saw her on April 3rd she was in an extreme state of collapse, and it was clear that life could not be saved. Her abdomen was distended, but not tense, and there was no swelling in the right femoral region, which was given as the seat of her hernia, although pressure with the pulp of the index finger over the right femoral canal elicited pain. No enlargement of the thigh was noticed in the region into which the hernia was subsequently traced. An exploratory operation in the femoral region was, however, determined upon, based upon the good old practice of first examining, in every case of intestinal obstruction associated with a hernia, the region in which the hernia existed. The operation was carried out in the usual way by a vertical incision of the soft parts over the crural canal, and the exposure of the crural sheath, which did not seem to be expanded, although on palpation over the femoral canal it was thought to be slightly distended. The sheath was then opened with great care, when a small piece of tissue which looked like omentum was seen, but no bowel; the femoral ring was quite clear and upon passing a director it was slightly enlarged upwards and inwards; as a result of this action a piece of pale intestine which before had been collapsed and had not been seen, suddenly on its distension arched forwards in the femoral canal, and was lost downwards through a narrow opening at the apex of the femoral sheath, an inch or an inch and a half below the femoral ring. At this point the bowel was strongly held and strangulated; upon a grooved probe director this ring or canal was divided, when he was enabled to draw out of a space situated below and to the inner side of the opening in the femoral sheath at least four or five inches of highly congested but not otherwise injured intestine, and reduced it easily into the abdominal cavity. The operation was thus completed, but the patient sank as expected, and died a few hours later.

A partial post-mortem examination could alone be obtained, but from the specimen which was secured by Mr. Lyster, the house surgeon of the hospital, and which, as dissected and mounted by Mr. Shattock, is now in the museum of the Royal College of Surgeons of England, preparation 2977A; it seems clear that the sac of the femoral hernia had been forced through a rupture of the femoral sheath at its lowest part or apex into the connective tissue of the thigh on the inner side of Scarpa's triangle, and that the seat of strangulation was at the neck of the sac, which was not as is usually the case, at the femoral ring, but at the orifice of the femoral sheath through which the hernial sac had been forced. *Remarks.*—The case which has just been read is clearly a very unusual one, and as such is worthy of publication, indeed he had never seen or read of a femoral hernia being displaced as this must have been into the fatty connective tissue of the inner side of the thigh, with the seat of strangulation being at least an inch and a half below the femoral ring, its usual seat, and situated at the mouth of the opening in the femoral canal through which it was probably forced. Had there not been a distinct history of an old femoral hernia in this case there would not have been any local indication to lead the surgeon to suspect that the intestinal obstruction which the symptoms suggested was due to such a cause, for there was a total absence of all swelling, and the sign of pain on pressure over the femoral canal stood alone. Under these circumstances an abdominal operation might have been undertaken, and if so it would have been useless, for the seat of strangulation was outside the abdominal cavity, and could not by such a measure have been relieved for it must be emphasised that during the operation, when the femoral sheath was first opened, the bowel which was in it was not seen, for it rested in a bloodless and collapsed condition upon its posterior wall; and it was not till the crural ring was enlarged that it made itself manifest by bulging forwards and arching downwards from the femoral ring to the seat of its stricture and the apex of the femoral canal. This portion of exposed intestine was quite healthy-looking and pale, and contrasted strongly with the deeply-congested bowel which was subsequently withdrawn from the displaced hernial sac. The cause of the displacement of the femoral hernia in the case recorded must doubtless have been mechanical, and was probably due to the forcible attempt by the patient at reduction of the hernial tumour after its descent. The force employed having brought about primarily a rupture of the femoral sheath at its lower end, and secondarily the gradual herniation of the femoral sac with its contents into the space in the connective tissue as demonstrated by the dissected specimen. It is probable also that what the patient described as her bilious attacks were due to a partially obstructed hernia. There was, therefore, in this case an example of a third variety of displaced femoral hernia: the *first* being the well-recognised form in which the small strangulated femoral hernia with its sac may be pressed out of sight and reduced, still strangulated behind the abdominal parietes, The one of "*reduction en masse.*" The *second* being where a large femoral hernia by some rupture of its sac, may show itself as a tumour in the subcutaneous connective tissue above or below Poupart's ligament; and the *third* as a displaced hernia following the course of the case first described. In the many varieties of "displaced inguinal" hernia which have been described, and particularly by Mr. J. Birkett and the reporter of this case in his "*Practice of Surgery,*" the injurious effects of misapplied force have been fully recognised; indeed, it seems probable that in all the varieties of displaced inguinal hernia it should be regarded as their probable cause. In the case now under consideration of femoral hernia, as in its other varieties, the same conclusion has to be drawn, and the truth of the following aphorism enforced:—"That as in the treatment of every variety of obstructed or strangulated hernia, forcible taxis is the direct cause of all cases of displacements of the inguinal or femoral varieties, as well as of rupture of the sac or sac's contents, so forcible taxis ought strictly to be avoided.

The PRESIDENT said he had never met with exactly

this variety of hernia. He raised the question whether taxis ought ever to be applied to a strangulated hernia, a practice which he had abandoned, he believed, with advantage. He thought that if this view were endorsed by a surgeon of the author's experience it might produce a good effect in practice, both private and in hospital, where he had often seen violent taxis applied in such cases to the detriment of the patient.

Mr. GOLDING BIRD remarked that though the author had called it a femoral hernia he gathered from the paper that the crural canal was found empty. If so, was it rightly so described? A parallel case was reported by Creely in which the hernia came down under Poupart's ligament and did not go into the crural canal at all. Having come down, by whatever path, taxis seemed to have ruptured the sac and produced the condition which he had described. He thoroughly endorsed what the President had said as to the unadvisability of employing taxis in strangulated hernia, a practice which he thought was productive of more harm than good.

Mr. BRYANT, in reply, said it was clearly a femoral hernia, though when he first opened the sac the crural canal appeared to be empty, the intestine being collapsed and flat. When he divided the ring to get more room some flatus came down, and then the intestine became visible. He was disposed to agree with the President in his remarks on taxis, at any rate in regard to femoral hernia, but an inguinal hernia was rather different. He would not, however, employ taxis even in the latter unless the patient was under an anæsthetic, and then only very gently. Anything like violence would be iniquitous. In a scrotal hernia the neck was usually very large, and it was much mixed up with omentum, so that the bowel was not so readily injured as in a femoral hernia.

Mr. CUTHBERT S. WALLACE on the

#### TREATMENT OF WOUNDED JOINTS.

Wounds of joints fall into three groups. (1) Those in which the joint injury is complicated by compound fracture, and in which the wounded joint is the lesser injury. The treatment of such a case depends more upon the complicating wounds than on the wound of the joint. (2) Wounds, or probable wounds of joints. (3) Doubtful wounds of joints, such as perforating or punctured wounds. The notes of three cases of the second group were read, one of which ended fatally, one recovered with a stiff knee, and the other with a movable joint. The treatment of such injuries was then discussed, and it was maintained that the cleansing of the wound must be mechanical, and, therefore, that all dirty tissue should be cut away with knife or scissors, and a douche if used was only beneficial because it removed fragments of dirt or soiled tissue, it was, therefore, sufficient to employ sterilised saline fluid, and that antiseptic solutions were unnecessary. A search for a wound into the joint was not recommended, as if found, it was unlikely that much good could be done, and if an opening was accidentally made into the capsule a serious harm might result. If the opening into the joint was obvious, it was recommended to close the capsule without irrigation of the joint and await developments. The notes of five cases of punctured wounds of joints with resulting infection were then read. In four instances practically full movement was obtained, and in the fifth, movement was limited to about one-quarter that normally present. It was thought that the best treatment of such cases was arthrotomy with sterilised saline solution and suture of the joint cavity. This process could be repeated once or twice if the condition required it. After this, if the temperature remained high, the incision into the joint could be left open, and lavage practised daily. The writer thought that it must be recognised that if the infection reached the peri-articular tissue, surgery could do but little, save opening any abscess that might form, or in ablation of the limb. Drainage by means of tubes through the joint or continuous irrigation were likely to do more harm than good.

The President agreed that in these cases antiseptics were not only useless but were often positively injurious. For many years he had employed only irrigations of normal saline solution, whereby his results had im-

proved. When a joint had suppurated it was not enough to irrigate it from one side to the other; the jet must be carried into the recesses to expel the matter. With this treatment he had obtained very good movement even in very severe cases—gonorrhœal arthritis for instance. He wished to lay down the principle that once a joint was infected it could not be disinfected.

Mr. WALLIS observed that it would be an advantage to have some definite plan of treatment laid down for these cases. The author's cases resembled those he had brought before the Society in 1898. He had himself attempted what the author appeared to have attempted in his own cases; in one case the joint was ankylosed, in another there was fair movement, and in a third the movements were free. These perforating wounds of joints, if they became at all inflamed, might be treated by a fairly free opening and drainage, a plan which had given him excellent results. In one case the knee-joint was exposed for six weeks, yet movement, though limited, was good. The introduction of drainage tubes into the interior of the joint and the use of antiseptics was likely to bring about absolute ankylosis with protracted recovery.

Mr. ABBOT pointed out that it was long the practice in suppurative peritonitis to make a small opening and to irrigate the cavity, and that treatment was generally agreed to be of the most hopeless kind. It was only recently that they had made large incisions and turned out the intestines so as to enable them to cleanse the entire cavity, and they had thereby got improved results. As to the treatment of adhesions in joints, he asked whether forcible movements were likely to be of more benefit than could be obtained by simple massage.

Mr. WALLACE, in reply, thought that where there was a large outer wound and a small wound into the joint it was worth while giving the joint a chance. He insisted on the fact that cleansing the joint was a purely mechanical procedure, and it was no good trusting to antiseptics. He did not think that forcible movements could do any good.

Mr. MANSSELL MOULLIN read the notes of

#### FIVE CASES OF ASCITES DEPENDENT UPON CIRRHOSIS OF THE LIVER,

in which he had sutured the omentum to the anterior abdominal wall, with the view of establishing a collateral circulation after the Drummond-Morison method. Two cases died, one four weeks after the operation from pleurisy; the other, one week after from exhaustion. In both of these the operation had been performed too late. The disease was too far advanced, and there was no time for the development of a collateral circulation. In one of them, who weighed over 15 stone, the liver was only three pounds and a quarter. The three other cases were discharged from hospital relieved. One could not be traced. The two others were alive and at work at the present time, two years after the operation. Mr. Mansell Moullin pointed out that so far as ascites was of mechanical origin there could be no question that the operation was capable of giving relief. There is the clinical evidence that a certain proportion of patients suffering from cirrhosis of the liver, who are treated by repeated tapping, get well at last even after they have been tapped twenty or thirty times; and there is the pathological evidence of the enlargement of the ordinary anastomotic channel between the radicles of the portal and systemic circulations; and of the very great development of accessory channels in the freshly formed adhesions, as, for instance was shown most plainly by one of Morison's cases which died from an operation for ventral hernia two years after the omentum had been sutured. If on the other hand the ascites is held to be not mechanical, or not wholly mechanical in origin, but to be due to the impairment in activity of the liver cells consequent upon the defective blood supply, it is equally the fact that the only hope of restoring the activity of these cells, and giving them a better blood supply, consists in establishing a number of vascular adhesions between the contiguous surfaces of the liver and the abdominal wall, at a period when compensatory growth is still possible



Mr. Mansell Moullin pointed out that the operation, if the cases are properly selected, is not one that is attended by any serious degree of risk. It is true that the mortality, as judged by statistics, has been very high up to the present; but this is always the case with new operations, and is due to the fact that many of the cases are unsuitable, often because of disease in other organs of the body, and that there is a tendency to look upon the operation as a last resource, one only to be performed when everything else has been exhausted. With better selection and earlier operation, there is no reason why the mortality should be appreciably higher than that of exploratory laparotomy. So far as technique is concerned, a median incision above the umbilicus is the most convenient, and gives least trouble afterwards. Through it the whole of the upper surface of the liver can be reached, and the omentum can be fixed to the abdominal wall by sutures passed from its peritoneal surface. Drainage is unnecessary, and may be dangerous, as offering additional risk of sepsis. The fluid always collects again, but it collects in the lowest part of the abdomen, and does not interfere with the formation of the adhesions. If it becomes excessive at any time it can be drawn off again; and this, as shown by the history of the cases which recovered, may have to be done many times in the course of the first few months, until the anastomotic channels have enlarged sufficiently. Ascites is a late and a very serious symptom in cirrhosis, aggravating all the rest, and hastening the progress of the disease. If, therefore, it is not complicated by diseases of other organs, and if the accumulated fluid does not quickly disappear under the influence of iodide of potassium, it seems more rational to try and establish an efficient collateral circulation, without further delay, by an operation which is not, under such conditions, attended by a serious degree of danger, than to allow the patient to drift on in a state of perpetually increasing misery, relieved now and then by tapping, until, in the vast majority of cases, his strength sinks so low that it is too late to do anything more than watch the progress of the disease.

Dr. CAMPBELL THOMSON referred to a paper on this subject which he had read last session before another society in which he had drawn a distinction between the cases in which the ascites was directly due to the cirrhosis of the liver and those in which it was caused by peritonitis resulting from the cirrhosis. The latter were the cases in which operation was likely to prove beneficial, as proved by post mortem investigations. The former class usually proved rapidly fatal. The cure, when it took place, was presumably due to obliteration of the peritoneal cavity by the formation of adhesions, just as pleurisy was cured by the adhesion of the layers of the pleura.

Dr. SANSONO did not think that clinically it was possible to differentiate between the cases of pure cirrhosis, and those associated with peritonitis. Cirrhosis was not a simple condition, on the contrary it was a very complex thing, and he was not disposed to accept the previous speaker's conclusions in regard to the cases which recovered, and those which did not. Therapeutically it was necessary to modify the balance of circulation, and he thought surgical measures constituted a better way of effecting this than the old-fashioned plan of tapping with copious diaphoresis.

Dr. NORMAN DALTON agreed with the author that a great deal depended upon the condition of the other organs. Certainly if there was marked œdema of the feet the results were not likely to be as good as when there was only ascites. He thought that the higher the incision was made the better, in order to guard against the occurrence of ventral hernia which so often proved fatal later on.

Mr. MANSSELL MOULLIN, in reply, agreed with the last speaker in respect of the best site for the incision. He had operated after one or two tapplings, i.e., somewhat early in the history of the ascites.

## Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, October 12th, 1901.

### CONTUSION OR RUPTURE OF INTESTINE.

THE *Pesth. Med. Chir. Presse* contains the following interesting case, recorded by Dr. J. Toth.

The patient, about an hour and a half after supper, was kicked on the abdomen by a horse, upon which there was inclination to vomit, but none actually took place. The pain, however, was so great that the patient had to sit down on the ground in a doubled up position; he was then taken to bed. The condition on the following day was the following: The face had a pained expression; the patient lay in bed turned towards the right, with the right thigh drawn up. The breathing was costal and superficial; there was no abdominal respiration. The abdomen was distended, painful to pressure over the whole surface, but more so about the umbilicus to the right, where there was a feeling of hardness. There was no trace of injury externally. On percussion there was dullness in the lower part, which varied with change of position. Collapse was extreme. Temperature 38 C., pulse 120, small and easily compressed. There was no vomiting and no action of the bowels. One hour after admission the patient passed 300 to 400 c.c.m. of bright red urine, but there was no further attempt. In determining a diagnosis the question arose as to whether the peritonitis clearly present was due to contusion or to rupture of the bowel. The answer to this question was not easy to obtain, as the symptoms present might be due to either injury and the hæmaturia still further complicated the matter. The hæmaturia was evidently due to traumatism of the kidney and not to any injury to the bladder, as after exclusion of rupture of the bladder, the chief symptoms of rupture of bowel, such as vomiting, action of the bowels, and disappearance of liver dullness were absent, the diagnosis must be determined by the further course of the case. As a matter of fact, both vomiting and action of the bowels took place about midnight of the following night, the vomit being slimy and of a green tint. The abdomen became more distended. A diagnosis of rupture of bowel could now be made with confidence. Death took place the following day.

The autopsy showed meteorism, no trace of external injury either of the skin, the subcutaneous connective tissue, or of the muscular structures. On opening the abdomen a foul odour was perceptible. The abdomen contained about two litres of thin dark blood. The peritoneum was covered over most of its extent with a removable pseudo-membrane and beneath this was deeply injected. The pseudo-membrane glued together the coils of intestine. On the duodenum there was loss of substance over about one-fourth of the periphery. The loss of substance extended to the lumen of the bowel, the edges were rather sharp, and the rent lay transversely to the axis of the bowel. There was a large quantity of blood-clot lying among the adjoining intestines and adherent to them. The bladder was intact. The case shows the unreliability of the supposed symptoms of rupture of intestine.

### CONSTIPATION OF THIRTY-FIVE DAYS' DURATION.

The *Munch. Med. Woch.* has the following:—

The patient, a girl, æt. 14, in spite of strong purgatives,

had had no action of the bowels for a week, nor had she passed any flatus. The constitutional condition was good. In the left iliac region, reaching on the right to the middle line, and upwards to above the umbilicus, was a tumour, tender on pressure. From the rectum, which was empty, it could be felt as irregular in outline and slightly doughy. The diagnosis was obstruction by a faecal tumour in the sigmoid flexure. The treatment was light, digestible diet, and enemata of water six times a day. Occasionally they were mixed with oil, salt, or vinegar and water, but a litre was not retained much more than a minute. As the appetite, which had been good, now changed to complete anorexia, and vomiting came on, an attempt was made with ext. colocynth and croton oil, but both drugs and atropine also were without any effect. After sixteen injections the bowel was washed out twice daily for two hours at a time. At the first washing out, the water broke up some of the mass and returned mixed with a good deal of faecal matter. The obstruction was overcome, the vomiting ceased, and the appetite returned. The irrigations were repeated twenty-two times, the tumour had then disappeared, but the patient at the time of reporting had not been cured of her habitual constipation.

The *Col. f. Gynækol.* 30, 1901, contains an account of a new way of treating

#### CHRONIC PELVIC EXUDATION,

by Dr. O. Polano, Royl University, Frauen Klinik Greifswald. The method consists in the application of warmth by means of an apparatus devised by himself and Dr. Klapp. Without entering into minute details difficult to understand, the instrument may be said to distribute heat derived from the burning of gas by a Bunsen burner equably over the lower part of the abdomen, the back, sacrum, and hips. A thermometer is placed on the lower part of the apparatus that registers to 150° C. On the first day a temperature of 120° C. is applied for twenty minutes. On the following days the heat is greater and the sitting is gradually extended, so that after a week a heat of 136 to 150 C. is applied for three-quarters of an hour at a time. It is a safeguard to know that the heat reaching the body is always below that registered by the thermometer. The action on the skin is very marked, and the patients, especially the obese ones, sweat profusely, and through a speculum the cervix uteri is seen to secrete freely. The only sensation perceived when the apparatus is rightly applied is a slight prickling. To relieve this a damp cloth may be placed on the forehead. When the heat has been applied long enough cooling may be brought about within five minutes by turning off the gas. When this is done the patient is thoroughly dried, a towel over wadding or lint is then wound round the abdomen and the patient is put to bed for an hour.

### Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, October 12th, 1901.

#### MYELITIS ACUTA.

REDLICH, in his lecture, gave a *résumé* of the pathological anatomy of myelitis, which he was pleased to divide into two divisions according to Leyden's nosology. The symptoms, he said, had long been known to the profession, which were then attributed to myelomalacia

as the initial cause of the disease. It is now ascertained that there are now two causes: (1) the true inflammatory form; (2) the hæmorrhagic or hæmatomyelia, differing little, if any, clinically, from the inflammatory. This is not to be wondered at, as inflammation and hæmorrhage have much in common. Myelitis may be either transverse, disseminated poliomyelitis or compression myelitis. Notwithstanding the modifications in the classification, it cannot be denied that there is always a certain amount of infectious poison at the root of the disease. This has been amply proved in poliomyelitis by bacterial examinations. The same pathogenic agent may be the origin of other obscure cases. Weichselbaum and others have recently gone so far as to affirm that the original cause lies in a streptococcus in the cerebro-spinal meninges.

Be this as it may, we have many proofs of myelitis following on attacks of influenza, typhus, and slight affections of the throat, as well as after confinement. Post-infectious myelitis is not yet unknown after an accident or shock to the system, although these cases may even be hæmorrhagic in nature, as many of them are found to be of the disseminated type which lends much colour to the assumption. Tubercle, syphilis and gonorrhœa are too well known in chronic myelitis to require notice; while the acute are usually produced by alcohol, lead, arsenic, and carbon monoxide.

The site will vary from the bulbar to the cervico-dorsal region. Its progress is often more than acute, and may be designated "acutissima." Commencing low in the cervical region it may rise rapidly, and produce bulbar paralysis, endangering the life of the patient, and as rapidly recede, but never perfectly recovering functional activity. As a rule it produces cystitis-trophic disturbances, and ultimately gangrene of the extremities.

The transverse, disseminated exudation and hæmorrhagic varieties are all capable of retrogression and partial recovery; or may merge into the chronic state.

The microscopical pathology is as variable as the symptoms. According to some observers it has been affirmed that the inflammatory process may first assume a transverse course, and in its diffusion induce the disseminated form, and finally ending in poliomyelitis. This order has been disproved and it is shown that the reverse order may be followed.

Acute poliomyelitis in the fresh state has all the appearance of an inflammatory process with a preceding vascular lesion, not in the anterior horns alone but in the arteria spinalis anterior and arteria centralis as well. It is possible that in individual cases, as described by Charcot, acute degenerative phenomena in the ganglionic cells may occur, but this is not constant. The acute form of poliomyelitis has a preference to form centres in the grey matter resembling multiple disseminated myelitis with vascular infiltration as seen in young individuals.

In other cases of acute myelitis the histological appearance assumes two other different forms—first, degenerative changes in the nerve element—nerve fibres and axis cylinder which sometimes have vacuolæ and at other places swellings. The vascular part has fatty degeneration with infiltration of the neighbouring structure. In some of the cases necrosis of all the tissues is seen, most pronounced in the vascular region.

In all the cases there is decided changes in the

meninges. In conclusion, he thought Mayer's theory of vascular changes insufficient for all the changes of acute myelitis; while Brun's hypothesis of intoxication did not always appear to explain the real origin; neither did Virchow's thrombosis or embolism theory throw light on this much obscure inflammation.

In the greatest number of cases cold, intoxication, injury, &c., would be found as the origin of the disease, while bacteria, embolism, &c., would appear as subsequent complications.

## The Operating Theatres.

### WESTMINSTER HOSPITAL.

**SUPPURATION OF MIDDLE EAR EXTENDING TO LATERAL SINUS.**—Mr. WILLIAM TURNER operated on a child, *æt.* 5, who had been sent up to hospital by Dr. Joyce, of Battersea, with a diagnosis of thrombosis of the lateral sinus, and who had been admitted the day before with the following history:—The child had been taken ill with severe pain in the right ear ten days before admission. Two days afterwards there was high fever with delirium, which continued for three days: The temperature then came down, and the little patient became conscious, but still complained of pain in the right ear, and the head was kept turned to the opposite side. Three days before admission the child had a rigor, and vomiting occurred once or twice without any apparent cause. The temperature when brought to the hospital was 100, and it went up to 102 the night before operation. There was no discharge from the ear on admission, and there had been none during or previous to the illness. The patient seemed very ill, and was in constant pain over the ear, but had no signs of meningitis or trouble over the mastoid process itself. A little swelling was noticed occupying the upper third of the sterno-mastoid muscle on the right side apparently due to inflamed lymphatic glands. The edges of the right optic disc were more blurred than on the left side, and the retinal veins were engorged. On the morning of the operation some purulent fluid was found in the external auditory meatus, which on microscopical examination proved to be pus; the child was deaf on that side; no perforation could be discovered in the membrane, which, however, was swollen and red, but there was no pulsation visible on it. It was deemed, therefore, necessary to explore the mastoid. Chloroform was administered, and the usual semi-circular incision behind the ear made down to the mastoid process, the periosteum excised, and a gouge put on over the position of the antrum. The outer wall having been removed pus was immediately found, and was traced forwards and backwards into the middle ear in front and to the lateral sinus behind, the bony canal of the lateral sinus being found full of pus. It being deemed inadvisable to deal with this until the internal jugular vein had been tied in the neck, this wound was covered up and an incision made at the anterior border of the sterno-mastoid at the lower part of the neck, and the internal jugular vein separated from the carotid artery and ligatured in two places with catgut but not divided. This last wound was now stitched up, covered with collodion dressing, and the operation on the sinus continued. All the pus was traced downwards and found to go to the jugular foramen; this pus was removed by means of small swabs on a probe; next the vein itself was

opened and found to bleed readily, showing that thrombosis had not occurred at that spot. The hæmorrhage was easily stopped by means of a small plug of gauze. An incision was then made in the neck corresponding to the swelling just below the mastoid process; a lot of inflamed glands were found which were not suppurating. The internal jugular vein was exposed just below the jugular foramen, but there was no pus around the vessel. A drainage tube was left in this opening. The tympanum was then freely opened up with a gouge and made to connect with the original opening in the antrum. The facial nerve was touched during this process, as was evinced by spasm of the muscles on that side, but was not divided. The subdural space was also opened, but no pus found in this situation. The posterior part of the cartilaginous lining of the external auditory meatus was incised to make the meatus itself larger; the ear put back into its original position; the edges of the first incision were stitched up; in this manner the packing came out through the external auditory meatus instead of through the incision over the mastoid. Ordinary dressings were applied. The operation lasted two hours and fifty minutes, and the child took the anæsthetic very well. Mr. Turner said that the diagnosis made before admission was absolutely confirmed by the operation. The symptoms, he considered, were certainly obscure on account of the child never having had any previous trouble in the ear, also on account of the fact that there had been no discharge from the ear until the morning of the operation, and then so slight that it had to be microscopied to prove it to be pus, and also because there was no redness, swelling, or acute tenderness over the mastoid process itself. The case having been dealt with, and the patient only having had one rigor three days before led him to hope that pyæmia would not intervene, as even if a portion of clot in the vein had been separated, it did not follow that it was necessarily infective. With regard to the operation, he remarked that the "complete" operation had been performed and all the possible situations for pus explored; the opening into the subdural space, he pointed out, was originally unintentional, and although it proved that there was no trouble there at the time of operation, it undoubtedly left a risk of meningitis intervening from the wound, though from other cases where the same had been done the gauze packing has usually prevented this complication. No real difficulty, he said, was experienced in finding the jugular vein deep in the neck, although it had to be done in such a small space owing to the age of the patient; but with the muscles well retracted with blunt hooks an incision of only about an inch long was necessary. The object of tying the vein low down, he explained, was to prevent septic clots passing down from the lateral sinus to the lungs and heart and setting up general pyæmia. The latter part of the operation, when the antrum, tympanum, and posterior wall of the meatus were converted into one cavity and the cartilaginous portion of the ear incised so as to increase the external auditory meatus to allow the packing to come out there, was done for several special purposes—first, to follow up the primary origin of the suppuration in the sinus; secondly, to avoid continued suppuration and necrosis occurring from trouble in the bone left uncovered; and thirdly, to allow the ear to go back into its original

position, and not produce an unsightly opening behind, accompanied by the bulging forward of the auricle. This latter part of the operation, he said, was more usually done in chronic cases of continued mastoid supuration, but it seemed to him the most thorough method of finishing the present operation, and if the child got over the acute symptoms, the after-treatment would thus be rendered very much easier.

Unfortunately, the child succumbed in thirty-six hours, with symptoms of acute meningitis coming on six hours before death, but at the post-mortem examination no physical signs of this condition or of any condition to lead to death could be found, and the operation wounds were all perfectly satisfactory, no pus being found in any of them. The only abnormality discovered was some early endocarditis of the mitral valve. The only presumption, therefore, as to the cause of death, Mr. Turner thinks, was that it was due to acute septic absorption from the original trouble.

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## The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, OCTOBER 16, 1901.

### REFORM OF THE ARMY MEDICAL SERVICE.

If henceforth the United Kingdom is to maintain a great Army it will be clear to every level-minded citizen that the organisation and equipment of that force must be of the best in every particular. The present war at the Cape has disclosed many faults in our military system, and nowhere more emphatically than in that important branch included under the title of the Army Medical Service. For many years past that Department has been hampered by official neglect and discouraged by many obstacles, both social and professional, that have been placed in its path. The inevitable result has been a growing unpopularity of the Army Medical Service, and an absolute lack of any businesslike organisation for supplying the medical wants of a large army in the field. Nemesis followed close on the outbreak of the Boer War, the scandals of which have sunk deep into the hearts of the nation. The conditions of the

military hospitals have undoubtedly been such as to add materially to the avoidable mortality among our sick and wounded troops. In plain words, the Army Medical Department broke down utterly under the strain of an arduous campaign. The true position of affairs at the Cape would probably never have been known had it not been for the courageous attitude of Mr. Burdett-Coutts, who, almost single-handed, has fought the hydra-headed officialism of the War Office, backed by a self-satisfied and nonchalant Government. Mr. Burdett-Coutts's exposures in the House of Commons wrung from Mr. Balfour the Commission of Inquiry, which resulted in a complete whitewashing of all concerned in the failure of the military hospitals. Mr. Burdett-Coutts exposed the defective constitution of the Commission, the disingenuousness of its methods of inquiry, and the fatuity of many of its findings in a series of criticisms that have never been fairly answered. Indeed, apart from plentiful abuse, the main recognition of the truth of his charges has lain in the subsequent action of the Government. Thus, following the Army hospital inquiry a Board was appointed to report on the best means of reorganising the Army Medical Service. The report of that body has been issued, and has given rise to a chorus of more or less hearty journalistic approval in all parts of the United Kingdom. Undoubtedly it contains, as we pointed out in our last issue, the germs of many useful reforms. At the same time it may be questioned whether it reaches the root of the matter. Broadly speaking, the trend of the whole recommendations lies in the attempt to make the Service more attractive to the medical profession. Would it not be more vital to consider first the inherent faults that have led to the present breakdown? What has Mr. Burdett-Coutts to say upon the matter? In a letter to *The Times* of October 8th he has published a well-informed and scathing criticism of the Government proposals. In an article like the present it is impossible to deal with his remarks *seriatim*, but readers who are interested in Army medical reform will do well to read, mark, learn, and inwardly digest every line of that able communication. His list of things left unreformed is formidable enough, in all conscience, when it is remembered that the Committee was appointed by the Government to draw up a scheme for the future organisation of the Army Medical Service. What can be the value of a report that leaves untouched the present and future position of the Militia Medical Staff Corps, the Militia Medical Reserve, and the Volunteer Medical Staff Corps, or the questions of an Army Medical Reserve of the employment of civilian doctors in war time, of the employment of civilian nurses and orderlies, of voluntary civilian hospitals, of the Red Cross Society, of the control of hospital orderlies, and of a number of other important matters bearing upon hospital administration that have been brought prominently into notice during the present campaign? As to what has been actually suggested we pointed out last week:—“One of the great aims

of the Committee has been to bring the Army Medical Service into closer and more sustained relations with the profession in civil life, and therein, unquestionably, lies an element of success of considerable importance." There can be no doubt that the newly-qualified man wants a practical training in professional work that he cannot get in ordinary military life. Such training he can get by holding residential posts in medical institutions and by post-graduate work of various kinds. We protest, however, in the strongest way against the assumption that the best and most suitable men for the service will ever be obtained by examination tests. The high standard examination is at best a feeble guarantee of the possession of the qualities necessary to make a sound and conscientious medical practitioner. Yet that appears to be, broadly speaking, the upshot of the whole report. As Mr. Burdett-Coutts remarks:—"The scheme starts on a wrong basis, or at least on an extremely narrow one. It seems to assume that the Army medical breakdown proceeded from the inferior scientific status of the Army doctor." Fortunately the suggestions of the report are not final, and in the present stage will fulfil the useful purpose of raising free and adequate public discussion.

#### THE ÆTIOLGY AND CONSEQUENCES OF MOVABLE KIDNEY.

A CERTAIN number of practitioners, it is to be apprehended, still regard movable kidney as an extremely rare, and even doubtful, lesion, although an attentive study of the fairly copious literature of the subject during the last few years should convince the most refractory that the condition is not only tolerably common but is often fraught with exceedingly distressing consequences to the unhappy possessor of the displaced or nomad organ. The fact that movable kidney is met with in a very large proportion of patients suffering from neurasthenia, according to one authority as many as 80 per cent., has led to the symptoms being regarded merely as neurasthenic manifestations, and not dependent upon the mobility of the viscus. It may indeed be conceded that movable kidney is frequent in neurasthenics, that in most instances it is not productive of serious injury, and that the symptoms referred to the kidney by the patient are frequently not due to its abnormal mobility but are really neurasthenic in character. On the other hand, as is pointed out by Dr. F. S. Watson, of Boston (*a*), while it is true that renal symptoms are often neurasthenic, it is also often true that the neurasthenic condition is directly dependent upon, and secondary to, the mobility of the kidney. This is clearly shown in the numerous reported cases in which movable kidney associated with painful crises has, in persons of previously good health and with no previous evidence of a neurasthenic tendency, been followed by serious impairment of the general health, and by the gradual development of well-marked neurasthenia, in whom

total disappearance of the symptoms and restoration to health have followed nephropexy. The consequences of movable kidney, moreover, are sometimes much more serious than the production of neurasthenia. We occasionally meet with acute symptoms due to rotation of the organ upon its horizontal axis, followed by occlusion of its vessels and consequent intense congestion, or twisting of the ureter may lead to hydronephrosis, or, lastly, the previously movable kidney may become fixed in an abnormal and physiologically inconvenient position. Movable kidney is a purely mechanical lesion, resulting from a variety of causes, acting either alone or in conjunction. Sudden absorption of the perirenal fat, increase in size and weight of the kidney or downward pressure on the kidney by an enlarged liver or by copious pleuritic effusions. The last-named condition may be simulated by the effects of tight lacing. Traumatism especially in presence of one or more of these conditions, may, of course, be the immediate exciting cause of the displacement. In only a small proportion of cases of movable kidney are the symptoms so severe and refractory to milder measures that operative treatment is indicated. In many, probably in most, careful attention to dress, the avoidance of tightly pressing stays or bands round the waist or over the hips, together with the use of a suitably padded corset, will be sufficient to render life tolerable without having recourse to the operation of nephropexy. With practice the diagnosis of movable kidney is less difficult to arrive at than is generally believed, the important thing is to be always on the look out for this abnormality.

#### CANCER: ITS NATURE AND TREATMENT.

A REMARKABLE article (*a*) by Dr. J. H. Webb, of Melbourne, deals briefly with the ideas which its author holds on the subject of the ætiology of cancer, and, at greater length, with the method which he has adopted for its cure in certain cases. The ætiology of the disease, according to the author, may be briefly stated as follows:—In the first place Dr. Webb demands the granting of three postulates—(1) All secretions must have their uses; (2) consequently, the loss of any secretions, save such as are required for temporary requirements, must mean some sort of disorder; (3) all reproduction is subject to control, or else, given nutrition, it would be indefinite. "Now, in obedience to this law, there must be something that regulates the proliferation of the cell. It can only be a secretion, subjected to a higher power." This secretion is cholesterine, which is kept in solution by its natural aqueous solvent soap. It is the loss of this soap that permits cholesterine to separate from the living cell and cell-cancer to start. The uncholesterine cell is the uncontrolled cell." "If I were asked what is malignancy, I would reply, it is the crystallisation of cholesterine from the living cell." Working on these lines, Dr. Webb first came to the

conclusion that the cause of cancer must be the loss of the controlling effect of the cholesterine, and with that idea he injected cholesterine, at first—thoughtlessly, as he says—dissolved in ether. It then struck him that as the ether evaporated the cholesterine crystals reappeared, were absorbed and, were carried off in the urine. After some time he found that soap was the natural aqueous solvent, and accordingly he dissolved some crystals of cholesterine in soap solution, and injected the drug in this form. At the same time he administered thyroid extract, and also another substance—animal gum—which he afterwards discarded. The case was one of epithelioma of the face, which had been operated upon and had recurred. It got well in a month. The second case was an unnamed form of cancer, on account of which the patient had had half of his lower jaw removed. Dr. Webb injected the same solution which he had used in the former case, and the man rapidly improved. Then a curious thing happened. Dr. Webb discovered that the supposed solution of cholesterine was not a solution at all, as the crystals “unless they be crushed will not dissolve.” Accordingly he, thinking well, “innocently injected” a new solution which he believed to be more perfect. The results were most disastrous, as the disease returned with great rapidity and the patient died. His next case was one of malignant disease of the breast of two years’ standing. Here he again injected, as he thought, the cholesterine solution, which he subsequently, as has been mentioned, proved not to be a solution, and administered thyroid extract, discarding the animal gum. “In less than six weeks the whole tumour had disappeared, leaving a firm cicatrix, and this fibrous tissue in turn dissolved, so that in three months one would have hardly known that there had been any disease.” For fifteen months the breast remained well, and then the patient returned with a suspicious spot upon it. He reinjected her, and in a few days a slough came away—presumably from where the suspicious area had been situated—leaving an ulcer the size of half a crown. The injections were continued and the condition disappeared. After this Dr. Webb treated two cases with a stronger solution of cholesterine—a case of epithelioma of the hand and a breast case. In both instances he failed to check the course of the disease. At this point Dr. Webb’s article fails to describe with sufficient accuracy the form of soap solution which he adopted in subsequent cases. We rather fancy that there is a misprint, and that he means to convey that he omitted the cholesterine. So far as we can understand, all subsequent cases were treated by the injection of soap solution alone, and the administration—when possible—of thyroid extract. In this manner he treated seven cases. Three recovered and four died. Two of the cases which died were advanced cases of cancer of the tongue, and in both the patients had a complete reprieve from pain. A fifth case died from an over-injection of the soap solution—a danger to

which the author calls attention. One case recovered in which “the whole of the interior of the mouth and cheek was one mass of cancer. The soap solution used is best made from Allen and Hanbury’s superfatted soap. Not more than a teaspoonful may be injected at the time, and various precautions must be adopted. Such in brief is Dr. Webb’s treatment and its results. Presumably the *rationale* of his treatment is that the soap solution by re-dissolving the crystallised cholesterine enables the latter to resume its “control” function. It is much to be regretted that the form in which the treatment is placed before its readers is not more methodical and systematic. Dr. Webb says that as he does not belong to any medical society he could only show his cases to his friends, and this being so we think that when he came to seek an opportunity for laying these cases before the medical profession generally, he should have taken more pains with the *form* of his communication. All through his article there is evidence of close and acute reasoning—if we grant the truth of the postulates which he lays down—but there is not evidence that he properly appreciates the importance of his subject. Otherwise, he would surely have dealt more carefully with it. Space compels us to withhold further criticism. We can do no more than call attention to an omission which in our opinion vitiates much of Dr. Webb’s work. In no single case is there a record that a microscopical examination of the growth was made, and its nature thus definitely determined. This is much to be regretted, but it can in the future be obviated. Will Dr. Webb have such an examination made in his subsequent cases, and then communicate the results of the treatment of cases the nature of which is beyond doubt?

### Notes on Current Topics.

#### Pantherapeutists and Others.

AN American writer, discussing the present aspects of the practice of medicine, groups practitioners into allopaths, homœopaths, quacks, and pantherapeutists, the last-named being those intelligent members of the medical fraternity who “draw their information from any and every source that is conducive to lessen the cause of disease and restore health to the afflicted.” In this sense we imagine every practitioner may be described as a pantherapeutist. It is not in accordance with general experience that professed allopaths, if there be any such, refuse or display reluctance to avail themselves of any remedy or mode of treatment which comes to their cognisance, whatever may have been its origin, provided it holds out reasonable hope of achieving the desired effect, which is the cure of disease; indeed, many even appear to dispense with this proviso, and forthwith give a trial to every new remedy which chance or skilful advertisement brings to their notice. Nor, on the other hand, have we found, in our limited experience of homœopaths, that they evince a distressing obstinacy

in adopting such measures and medicinal treatment as appeared best suited to attain their object; in other words, they, or some of them, recognise but one law, their duty to their patient. Even the quack, we may give him this credit, does the best he can, his usefulness being limited only by his extreme ignorance. It follows then that we are all panthe-raputists within the limits assigned by nature to our intelligence, and by the opportunities at our disposal, and further classification therefore appears supererogatory.

#### The Resignation of Professor J. M. Purser, of Dublin University.

THE School of Physic of Dublin University has suffered a severe loss by the resignation of Dr. J. M. Purser, King's Professor of the Institutes of Medicine. The news has come as somewhat of a surprise to his many friends throughout the United Kingdom. Dr. Purser has held the chair which he now vacates for close on twenty-eight years, and it is not too much to say that to his persistence and determination the medical class of Dublin University owe the physical opportunities they possess of acquiring a knowledge of the institutes of medicine, and to his scientific ability and power of teaching the knowledge itself. Dr. Purser has for years contended with the Board of Trinity College for adequate recognition of the importance of the subjects he taught, and he has contended with success. The necessary alterations, structural and otherwise, in his laboratories, have just been completed, and a sum of money has been granted to equip them in a manner consonant with the advances and requirements of modern science. For this Dr. Purser has fought for years, and it is on the eve of the fruition of his toil that he has chosen to resign in order that his successor may have the opportunity of personally equipping the new laboratories. There are few men who would voluntarily make such a sacrifice, and there are none in Dr. Purser's position from whom it could be asked. To most men, it would appear to be only right and fair, that, after the toil, they should have an opportunity of leaving their personal imprint on the result of their toil. Truly may his successor say: "Another man has laboured and I have entered into his labours." Dr. Purser's old pupils proved some couple of years ago that they were not unmindful of their master, and a medal—the John Mallet Purser Medal—was founded "to permanently record their appreciation of him as a teacher, their respect for him as a scientist, and their regard for him as a friend." Is it too much to hope that the Board of Dublin University will be seized by a similar impulse to honour the man who has given his life's work to advance by every straightforward way in his power the purpose for which their School of Physic was founded, the teaching of medicine? Dr. Purser has denied himself the opportunity of placing his personal imprint on the enlarged laboratories. Cannot the Board of Trinity College permanently record his relation to them, and by creating "The John Mallet Purser

Physiological Laboratories" perpetuate the memory of the man to whom the existence of the laboratories is due, and at the same time bring honour to themselves by so perpetuating his memory.

#### Professor Virchow's Eightieth Birthday.

OF all the distinguished figures in the world of medicine there is none more revered than that of Professor Rudolf Virchow. As a pathologist and a sanitarian he has long occupied a foremost place in science, which he still pursues with unabated ardour. Last week a number of distinguished persons met at Berlin to take part in the International festivities in honour of the aged professor, on the occasion of his eightieth birthday. The United Kingdom was represented by Lord Lister and Sir Felix Semon. Professor Virchow delivered a brilliant address of two hours' duration at the Pathological Institute, and chose as the subject of his discourse "The Progress of Pathology." During his career he has been prominent in politics, and in 1865, as a Liberal, he defeated Prince Bismarck's project for converting Germany into a great maritime power. It is interesting to note that he was, in consequence, challenged to a duel by the Iron Chancellor. He retired from politics in 1878, when he resigned his seat in the Reichstag. Since that time he has devoted himself entirely to scientific work. Virchow was made an honorary member of the Medical Society of London so long ago as 1856. His appearance in this country a year or two ago will doubtless be remembered by many of our readers. His life has, indeed, been one of enormous value to mankind at large, and merits any distinction that it is in the power of man to confer.

#### Small-Pox and the Conscience Clause.

IN an exceedingly able article on the subject of vaccination and the conscience clause, the *Saturday Review* deals in characteristically trenchant style with the absurd idea of recognising so-called conscientious objections in this connection. The intrusion of conscience into an affair of this kind, says our contemporary, "is a wicked anachronism. We are done with the days when a man for the sake of his own conscience could conscientiously burn his neighbour. Let us be as conscientious as we please for ourselves; if we must, let us burn ourselves, with as little advertisement of our reasons as may be; but let us see that we do it in such a fashion that our funeral pyre or the fumes of it do not offend our neighbours. Were it possible that rejection of vaccination brought no risk except to the rejecting person, it might be possible to give a guarded support to the conscience clause. But that support would have to be hedged about with restrictions and precautions almost impossible to carry out. At a time like the present, the conscientiously unvaccinated person should not be allowed in public except ringing a bell and clad in a warning garb. All means of public conveyance should be closed to him; all shops, schools, theatres, churches, hotels, public-houses, and restaurants should refuse

to harbour him; his linen should not go to the wash, his shoes to the cobbler, nor his letters through the post. Only on terms such as these should he be allowed to suffer for conscience sake."

#### Ascites.

SLIGHT ascites is frequently a very early symptom occurring in connection with malignant growth. By the usual diagnostic methods it is, however, extremely difficult to appreciate and recognise small quantities of free fluid in the peritoneal cavity. A characteristic sign, known as Landou's sign, affords in some cases a valuable help in the recognition of the presence of a small quantity of fluid in the abdomen. Landou claims to have been greatly assisted in arriving at a diagnosis by observing whether it was possible or not to grasp the uterus bimanually, that is to say, to make the fingers meet at the sides of the pelvis. With the patient lying flat on the back the uterus is slightly depressed and is described as giving the impression of resting on a cushion of air or a small collection of fluid. Continuing the examination, the patient is placed in the raised pelvic position and the thighs are flexed when the uterus can be examined bimanually without difficulty, and the fingers are found to meet at the sides of the pelvis, thus indicating that the fluid has gravitated in the direction of the diaphragm. It will be easily seen that for the success of this manœuvre the bladder must be empty. There is no malady in which it is more desirable to improve the chances of correctly diagnosing the condition as early as possible as in malignant disease and Landou's suggestion is sure to excite a considerable interest on this account.

#### The Inadequacy of the Lance.

IN the earlier days of the war one of the illustrated papers depicted two Boers, riding on the same horse, being pierced through by the lance of a British soldier. The illustration did not give one the idea of the lance being a gentle weapon, but we understand that the report furnished to the German Government by the medical expert sent out by them to South Africa is to the effect that the lance is too gentle a weapon to immediately stop a man or disable him for a reasonable time. The medical man in question, Dr. S. Schaffer, tells his Government that the lance is such a humane weapon that its efficacy in real warfare is greatly diminished, and therefore, if the German cavalrymen are to have a useful weapon in the lance the shape of the point must be changed; it certainly must not remain a round-pointed weapon. In Dr. Schaffer's report he gives details of the examination of several Boers who had been pierced through by British lances, and his opinion is that because of the roundness of the point it is possible for the lance to penetrate internal organs without very severe injury. In fact, the lance neither stopped nor fatally injured a large number of the Boers whose bodies had been penetrated by that weapon. Since in war the object of bearing weapons is to kill, or at any rate to disable, the sooner the lance is transformed into a more lethal instrument the better.

#### The Fight Against Malaria.

LOED BRASSEY is to preside over the meeting of those interested in the Seamen's Hospital Society. Occasion has been taken of the opening of the third winter session of the London School of Tropical Medicine to draw attention to the mission undertaken by Sir Francis Lovell to the East on behalf of the School, to which we briefly alluded last week. Lord Brassey promises us some particulars of this trip, and it is to be hoped he will not omit an explanation of the objects of Sir Francis Lovell's journey. This gentleman's mission is to elicit support and raise funds for the Seamen's Hospital Society, and for this purpose he is to visit Egypt, Aden, Zanzibar, India, Burmah, Ceylon, Perak, Borneo, Sarawak, Siam, Hong Kong, Japan, New Zealand, Fiji, Canada, and many other places. It is hoped that his efforts to raise money for scientific investigation in tropical hygiene and pathology will meet with a cordial support from the medical men in the towns he visits. Sir Francis Lovell is a very keen advocate for the education of medical men in tropical diseases, and if his success is in any way commensurate with the reasonableness of the cause he pleads there will be no disappointment in the ultimate result of his endeavours.

#### Detectives and Doctors.

OUR readers will remember some strong remarks made in this journal on the conduct of the authorities at San Francisco on the occasion of the occurrence of plague in that city. The State Board of Health of California have just paid a bill to a detective for shadowing the medical gentleman who had acted as Bacteriologist to the State Board of Health, and who was apparently obliged to leave that Board because he had dared to tell the truth and report the existence of plague. The attentions of detectives were also bestowed on Dr. J. M. Flint, Bacteriologist of the Marine Hospital Service, and on Dr. J. H. White, the quarantine officer. Assuming these facts to have been accurately reported it is clear that the Californian authorities exceeded their rights to a very considerable extent. It is simply disgraceful that medical men should be "shadowed" like common thieves because their duty forced them to disclose the disagreeable fact of the presence of plague in San Francisco. It is perhaps hopeless to expect anything to be done to have this matter properly inquired into, but at the very least the charge for the expenses incurred should be borne by those who set the spies to work.

THE opening meeting of medical session of the Meath Hospital took place on Monday last, when an address was delivered by Mr. William Taylor, F.R.C.S., Visiting Surgeon to the hospital, on abdominal surgery.

THE annual meeting of the Royal College of Physicians of Ireland will be held on Friday next, being St. Luke's Day. The annual dinner will take place in the College hall on the same evening.



### Drinking Water and Bad Teeth.

It is a pretty widely recognised fact that civilisation brings bad teeth. The why and the wherefore of that association is not altogether clear, although it seems fair to look upon the teeth as an organ of the human body which is gradually deteriorating because of the comparative falling-off in the exercise of their full function. In other words, savage man uses his teeth a great deal more than his civilised descendant. Other and more direct causes undoubtedly contribute to the decay of teeth, such as mouth-breathing, the use of hot and cold foods, and the manifold evils of the dyspepsia fiend. Some wise-acre dentists lately endeavoured to raise a scare by asserting that in Wales the prevalence of bad teeth was accounted for by the general softness of the water. In the first place, it may be very much questioned whether teeth are worse in Wales than in the two other countries of Great Britain. As for Ireland, if common belief is to be upheld, the people of the Emerald Isle are blest with remarkably good teeth as a nation. What hard drinking water has to do with the resistancy or otherwise of teeth to the processes of decay is not apparent. So far as modern dental science has solved the problem, the most important point in the care of the teeth is to have them well looked after not only in childhood but at all ages. The science of bacteriology has thrown its powerful light upon this as upon all, or nearly all, diseased processes in the human body. To clear out and fill a carious cavity is to remove from the mouth an infective centre of destruction and decay. In this matter an ounce of practice is worth a ton of theory.

### Longton—a Sanitary Scandal.

DESPITE the great improvement that has taken place in the national health during the past generation or two there nevertheless remain places that more or less merit the title of "plague spots." Among the latter may be included Longton, that is to say, if we may accept the startling charges brought forward some months ago by Dr. Allen, the Chairman of the Longton School Board, against the Sanitary Committee of the town. In order to substantiate his position Dr. Allen has published a pamphlet, in which he cites the local Medical Officer of Health, Dr. Dawes, and Dr. Fletcher, of the Local Government Board, as his authorities. He pointed out that Longton had almost consistently, from year to year, the highest death-rate of the towns in the Potteries, including Newcastle. With only three exceptions it had the highest infantile mortality each year for ten years of all the Potteries and Newcastle, and the highest of all towns in England and Wales on several occasions, and was always near the top of the list. Last year it was easily first, having the enormous rate of 327 deaths per 1,000 infants born during the year, as against 172 per 1,000 for the thirty-three largest towns. In 1899 Dr. Fletcher had reported upon the epidemic of diphtheria, but his recommendations had not been carried out, especially as re-

garded the establishment of an isolation hospital. Under these circumstances it certainly seems that Dr. Allen has fulfilled a public duty in his outspoken criticism. It is to be hoped that the Local Government Board will take decisive steps with regard to the health of Longton.

### How Diphtheria is Spread.

FROM time to time there are reported incidents which display the profound ignorance of many of the poorer classes with regard to the spread of infectious diseases. In the case of diphtheria it often happens in the heart of London, as elsewhere throughout the United Kingdom, that numbers of children visit the body of a playmate who has died of that terribly infectious disease. Again and again official investigation has shown that social gatherings in infected houses have been one of the active causes in fomenting an outbreak. Sometimes a prayer meeting is held in the house of the bereaved friends, but we are glad to learn that the custom is being abandoned among the miners of Dowlais, under the advice of Dr. Thomas, the Merthyr Medical Officer of Health. That gentleman states, however, that the practice of viewing the body of the infectious dead is still very common. In some instances he had heard of the children of neighbours actually being allowed to kiss the dead body. Comment on such a state of affairs is needless. How are the poor to be educated on such matters, which are of vital importance to their own welfare? A general knowledge of the laws of health and of disease, with special attention to infection, should form part of the education of every school child. At any rate it cannot be too widely known that it is unwise to kiss anyone who is suffering with, or has lately recovered from, a sore throat of any kind whatever.

### Employer's Responsibility for a Sick Servant.

A NOVEL question came up for trial at the Birmingham County Court a few days since, in which the employer's responsibility for his servant presented itself in a fresh light. A lady having been invited to visit a friend brought her servant with her. The girl fell ill with typhoid fever, entailing a long and, no doubt, somewhat costly illness. When it came to settling matter the lady paid the doctor's bill, but repudiated any liability for collateral expenses, including nursing, attendance, stimulants, &c. The case was settled by payment by the defendant of an agreed upon sum, so that the legal aspect of the question at issue was not adjudicated upon. Under ordinary circumstances one would expect one's guest to defray all out-of-pocket expenses incurred under such circumstances. The risk of being saddled with considerable expense in the event of the visitor or his servant falling ill is certainly not contemplated by householders who invite their friends to stay with them, to say nothing of the inconvenience and worry associated with an untoward event of this sort. In any case it is well within the power of the host to terminate the visit

forthwith, and it follows that any expense, even for maintenance, after that date might conceivably form the subject of an action at law. The guest, on the other hand, can hardly expect to find himself in a better position if his servant falls ill in a friend's house than he would if a similar accident happened at home. If the servant is incapacitated from work at home the master would be entitled, we imagine, to send her away, to a hospital if ill, but if he kept her, willingly or otherwise, he would not have any claim against the servant for maintenance, indeed, he would in all probability be constrained to accept liability for medical fees incurred on his servant's behalf.

#### The Cape Medical Council.

ACCORDING to the Annual Report of the Cape Medical Council the dentists in Cape Colony are the most law-abiding and obedient class. It was brought to the notice of the Council that dentists and other registered persons were actually advertising in the newspapers. This state of things, which is not unknown elsewhere, received the very careful consideration of the Council, and they came to the conclusion that they would call upon all persons who were behaving in this manner to immediately cease from their unethical conduct. To make the matter quite clear the Council passed a resolution declaring in set terms that advertising in a newspaper was improper and unprofessional conduct. The report of the Council states that in consequence of passing this resolution the dentists and other registered persons have withdrawn the objectionable advertisements. So completely did the resolution effect its purpose that formal proceedings were only necessary in one case, and in that one the administration of a caution was all that was requisite to secure the fulfilment of the Medical Amendment Act.

#### Careless Death Certification.

A WOMAN was sentenced last week at Glasgow to three months' imprisonment for having falsely reported the death of her child to the Registrar and making use of the medical certificate to obtain money from an insurance office. The judge sharply criticised the carelessness of the practitioner who gave the certificate on the mere affirmation of the mother, in apparent ignorance of the fact that this is the usual practice. Obviously the practice is one to be deprecated, but until the legislature renders it incumbent on the certifying practitioner to satisfy himself by personal inspection of the fact of death having taken place, and provides for his being suitably remunerated, this slipshod custom is likely to maintain. Although the number of such cases which come to light is comparatively small the ease with which the fraud can be perpetrated and the improbability of detection suggest the probability that this particular form of fraud is much more common than the figures would lead one to suppose. When the question of reforming the present system of death certification comes before Parliament no doubt this lapsus will be remedied.

#### The Differential Diagnosis of Small-pox and Chicken-pox.

IN a letter addressed to a contemporary Dr. G. S. Perkins calls attention to a simple means of distinguishing chicken-pox from small-pox, which deserves to be more widely known. He points out that the vesicles in chicken-pox are unilocular, whilst in small-pox they are multilocular. The practical result of this pathological fact is, that if a chicken-pox vesicle be pricked with a needle its contents can be completely evacuated and the cell will collapse, whereas in small-pox if one makes twenty pricks with a needle the vesicle will not collapse, because, being multilocular, it is impossible to empty it. There are, of course, many other points of difference between the two; indeed, small-pox is only likely to be mistaken for the less serious malady when the practitioner is not alive to the possibility of a mistake in the diagnosis. In small-pox, even in its modified form, varioloid, the initial constitutional symptoms are early and well-marked, with a considerable rise of temperature and cerebral disturbance. In small-pox the eruption is most abundant on the face and limbs, whereas in chicken-pox it is most abundant on the trunk, and its distribution is more discreet and general. Moreover, in chicken-pox the eruption appears in crops and not, as in small-pox, within a few hours of the first appearance of papules. Then, too, there is the characteristic fall of temperature on the appearance of the vesicles. An absolutely characteristic feature of chicken-pox is the appearance on the body of vesicles of different degrees of evolution, some being fully matured, while others have just made their appearance. In spite of these usually very distinctive features cases now and then occur in which even the most experienced may hesitate to formulate a definite opinion. In such cases twenty-four hours' observation will almost invariably clear up the mystery, and allow of a correct diagnosis.

#### A Lethal Coin.

A WORKING-MAN at York met with his death last week as the result of inhaling a half-sovereign. The history of the case, as revealed at the inquest, presents several points of unusual interest. The man was admitted to the York County Hospital in a state of impending asphyxia. In view of the history, the house-surgeon performed tracheotomy, and for three long hours searched for the coin, but in vain. Ultimately the man died of acute bronchitis. Post-mortem, the coin was found in the stomach, where its presence was explained on the assumption that the man had coughed it up and then swallowed it, death being due to the irritation set up by its sojourn in the trachea, in conjunction with pre-existing bronchitis and emphysema. The fact of the house surgeon having operated instead of sending for his senior elicited some comment, but every one conversant with hospital usages is aware that no medical officer would be justified in delaying intervention in an urgent case of this kind, especially when the operation is a simple one, such as tracheo-

tomy. No doubt the discovery of the half-sovereign in the stomach caused a doubt in the minds of the jury as to the wisdom of an operation having for object its removal from the trachea, and, after all, it is just possible that the respiratory embarrassment was caused by impaction of the coin in the œsophagus. On the other hand, it hardly seems probable that so small a coin would become arrested in the gullet. On the whole, the case was evidently one presenting considerable difficulty and calling for instant treatment, and the house surgeon is to be complimented on his courage and presence of mind.

#### The Small-pox Epidemic.

THE number of cases of small-pox under treatment in the hospitals of the Metropolitan Asylums Board has risen to 185, in spite of the constant discharge of valescents. This is, of course, to some extent, a satisfactory indication that the epidemic is not making very rapid headway. Some local excitement has been created in the district of St. Pancras by an excess of zeal on the part of the assistant public vaccinator, Dr. Purdie, who, it appears, vaccinated two children without having taken the precaution to demand the parents' consent. The magistrate refused to grant a summons for assault, but the guardians took a very serious view of the matter, and meted out to the too zealous officer a severe censure. Obviously, in a matter of this kind it is advisable to conform rigidly to the letter of the law, especially in dealing with the poor and uneducated classes. Where the reason is weak the prejudice is strong! The Press in general has criticised the pusillanimous action of the London School Board with the rigour it richly deserved. It is certainly both disconcerting and disappointing to witness such a lamentable want of moral courage on the part of a body of this kind, composed presumably of intelligent and earnest men. We will make bold to say that individually the great majority of the members of the Board believe in, and avail themselves of, the protection afforded by vaccination, yet they shrink from the idea of appearing to approve of a practice which they know or fear to be unpopular with a noisy but active minority of their constituents. "Thus conscience doth make cowards of us all!" The fault really lies with the Government, who lack the courage to act up to their own convictions by placing the carrying out of the Vaccination Act in the hands of a separate and independent authority.

#### New-Laid Eggs.

It seems not a little curious that no plan has been devised long ere this to prevent eggs from decay. The process is a perfectly simple one of putrefaction, due to the ubiquitous microbe, which gains ready access through the porous shell. What follows is only too familiar to all of us from painful experience. To prevent this peculiarly offensive putrefaction various plans have been tried from time to time, but nothing has hitherto answered the purpose sufficiently well to come into general favour. The main effort

has been usually in the direction of making the shell impervious to air and microbes, but it is quite likely that the interior of the egg contains micro-organisms before it is launched into the outside world. A more scientific procedure would clearly be to sterilise the whole egg in some way or other. That is said to have been done successfully by a Mr. Ellis, a chemist, of Stratford, New Zealand. Heat is clearly out of the question, on account of its coagulating or cooking the egg albumen, but he has perfected a cold sterilising process whereby eggs can be kept fresh in any climate and in any ordinary temperature from nine months to three years. If that be the case the egg trade, which has attained enormous dimensions in the United Kingdom, is likely to be revolutionised. It is quite common, at the present time, to find one or two bad eggs in every dozen bought at a shop, even when purchased, at a fair price of a respectable dealer. By the way, an ingenious apparatus has lately been patented for testing eggs by exposing them rapidly to the light in a revolving frame. —

#### Wet Nurses.

THE fashionable ladies in Paris are labouring under considerable difficulty in procuring wet nurses for their infants in consequence of a decree issued by the Chief of the Paris Police rendering it incumbent on wet nurses to give their own infants precedence in the matter of nourishment. Under certain circumstances the Prefect of Police grants permission for the child of a wet nurse to be partly bottle-fed, but this relaxation of the rules is allowed to such a limited extent that the practical effect of the new regulation regarding wet nurses in Paris is to secure the bringing up of the infants of wet nurses almost wholly by the breast. The pleasure-loving ladies of the leisured classes are face to face with a serious difficulty in consequence of the great scarcity of wet nurses, for they must either consent to their babies being brought up on the bottle, or else they must abandon their fashionable engagements and suckle their own offspring. Those who are acquainted with the ways of Parisian dames contend that the Prefect of Police will in the end find his order overruled.

#### Fatal Amateur Prescribing.

THE readiness with which some people swallow nostrums prepared or recommended by fellow-ignorami is astounding. The prescription is sometimes merely filthy, sometimes inert, but sometimes, unfortunately, it errs on the side of inconvenient and even dangerous activity. At an inquest recently held at Manchester, a labourer, who complained of pain in his back, died soon after drinking a solution of pearl-ash supplied by a neighbouring bleacher who dabbled in medicine. This amateur physician, it appeared, had collected a bookful of recipes and treatments which he doled out to inquiring friends. The inquest was adjourned for further evidence of the exact nature of the poison, and it seems not unlikely that this unauthorised practitioner may find, to his cost, that the practice of medicine has its responsibilities as well as its privileges.

### Gutter Journalism.

It is surprising to what lengths the editors of certain cheap dailies will go in the endeavour to conciliate the goodwill of the gutter population—for their utterances cannot possibly be addressed to persons of any refinement or intelligence. In last Monday's issue of *The Morning Leader*, to which a correspondent directs our attention, the editor asks, *anent* the St. Pancras unauthorised vaccination case, whether medical practitioners are "to be let loose in private houses to try all their unclean experiments upon children in the absence of those children's natural protectors," and, later, whether the practitioners aforesaid "may make defenceless youngsters the victims of their fads." We cannot legislate for good sense any more than good manners, and if this half-penny publication following Dogberry elects to write itself up an ass, it is not a matter which concerns us. At the same time, it is difficult to see what useful purpose can be served by this irresponsible coarseness.

### The Notification of Chicken-pox.

A CIRCULAR letter has been sent to the medical practitioners in the borough of Holborn intimating that on and after the 16th inst., the provisions of the Public Health (London) Act with regard to the notification of infectious diseases, and for a period of six months thereafter, will apply to chicken-pox. This is a very timely departure in view of the difficulty which exists in distinguishing between cases of varioloid and chicken-pox, a circumstance which is in large measure responsible for the extension of the present outbreak in the metropolis.

THE medical session of St. Vincent's Hospital, Dublin, was opened on October 8th, by an inaugural address by Dr. Michael Cox, F.R.C.P.I., Visiting Physician to the hospital. Dr. Cox's address dealt mainly with the present condition of the Poor-law nursing system in Ireland.

DR. WILLIAM CAYLEY has resigned the appointment of senior physician to Middlesex Hospital, which he has held for many years.

DR. D. J. G. WATKINS has been elected honorary surgeon to the Lincoln County Hospital, consequent on the retirement of Mr. W. Y. Cant, who has been made consulting surgeon to the institution.

THE officials of the borough of Thornaby-on-Tees last week commemorated the completion of Dr. Thos. Watson's twenty-one years of service as Medical Officer of Health of the town by presenting him with a silver salver, suitably inscribed.

### Correspondence.

[We do not hold ourselves responsible for the opinions of our correspondents.]

#### "LACHNANTHES TINCTORIA."

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—“Ubique” has thought fit to treat my letter to you with ridicule, and as he shelters himself under a *nom de plume*, I need not reply to his absurd criticisms

My only object in writing was to aid, if possible, Colonel Trench's generous offer of £1,000—made in gratitude for the recovery of his wife—towards obtaining an “official test” of the treatment in question. I can give the addresses of the cases I mentioned, if required.

As regards Morton—to whom “Damocles” (again a *nom de plume*) refers—I can state he was a discharged secretary, not “assistant,” of Dr. Alabone's. Had “Damocles” followed the case up he would have seen that in Morton's bankruptcy examination he, on oath, contradicted all the statements he had previously made! Like “Damocles,” I am surprised the Public Prosecutor did not take the case up.

I am, Sir, yours truly,

HENRY J. BUCK.

Clapton Common, N.E., October 7th.

P.S.—I must decline further correspondence. The question after all is, “Is the treatment in question effectual in restoring phthisical patients to perfect health?” I contend that it is so in a remarkable percentage, and shall continue to adopt it.

[The medical staff at the Brompton Hospital for Consumption are empowered to give a thorough trial to any treatment advanced as a remedy for pulmonary tuberculosis. The managers even offer to allow the discoverer to follow up the effects of the treatment in the wards. Here, then, is a ready-made opportunity to obtain a complete and impartial investigation of the—it appears to us—extravagant claims made for this particular treatment.—Ed.]

### THE CONGRESS ON TUBERCULOSIS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—If Colonel Le Poer Trench had read the whole of the correspondence on the above subject which has appeared in THE MEDICAL PRESS AND CIRCULAR he might not perhaps have fallen into the error of believing that my letter in your issue of the 18th ult. was written “for the purpose of bringing contempt upon a proposal he has put forward in the interest of sufferers from consumption.” For me to have done this would have been a work of absolute supererogation. The “lachnanthes treatment” for which Colonel Le Poer Trench asks the attention of the scientific medical world has all along been, is now, and is certain in the future to remain an object of contempt to that world without the help of any words of mine. It has been treated either by silence or with contempt in the editorial columns not only of THE MEDICAL PRESS AND CIRCULAR, but of all the other leading medical journals, and has neither now nor at any previous time received the smallest serious attention from the profession or from professional organs of foreign countries, where, as also in these islands, thousands of practitioners are ready eagerly to examine and try any remedy giving the smallest promise of utility in the cure of pulmonary tuberculosis.

The lachnanthes treatment has been regarded with contempt for the same reason that So and so's pills and ointment had been so regarded, namely, that its claims do not rest on scientific observation and experiment, but are solely supported by the testimony of “grateful patients” and philanthropic lookers-on of the intellectual calibre of Colonel Le Poer Trench. The treatment is further regarded with contempt because although—as I have said—our knowledge of the physiology and pathology of the lungs may not be complete, we have yet more than enough of solid scientific facts to enable us to perceive that it would be something like a miracle if advanced tuberculosis of the lungs were curable by internal administration of lachnanthes combined with inhalation of any form of vapour derived from that herb. Medical men of the world do not believe in miracles of that kind, especially when only wrought for gain upon patients attracted by advertisement. No, sir, my letters were not composed with the object of bringing contempt upon Colonel Le Poer Trench's proposal—if it has not had contempt

showered upon it by me or others it is only because it has been largely looked upon as beneath contempt—but to call attention to his attitude, among a vast number of the public, towards our profession as a body. It was I who, in your issue of August 28th, dealt with his letter of August 20th in *The Times*. In that letter he seriously expressed the belief that owing to prejudice or professional etiquette, or trades union rules framed by the General Medical Council and observed by the whole profession, a great discovery had been kept from the public since “the suspension of Dr. Alabone fifteen years ago, with the result that many thousands pronounced hopeless and incurable under the recognised treatments had been left to die.” Colonel Trench’s argument amounted to this, that Dr. Alabone was unjustly expelled from the profession for infamous conduct, whilst in truth the whole profession had been engaged in a conspiracy most infamous and murderous in withholding from their dying patients a remedy likely to save them and restore them to health. The profession was either too ignorant and stupid to be able to recognise a great discovery of inestimable value to suffering humanity, or too brutally selfish to avail themselves of it. This was a monstrous charge, and that it should be deliberately formulated by a man in Colonel Le Poer Trench’s position was the fact which seemed to me to deserve prominence as indicating the estimation in which the profession is held by great masses even among the so-called educated upper classes of society.

I am, Sir, yours truly,

October 10th, 1901.

UBIQUUM.

## Medical News.

DR. DURHAM, of the Liverpool School of Tropical Medicine, left on the 11th inst. on a scientific mission to Christmas Island, to investigate an outbreak of beri-beri among the coolies. Mr. B. Manson, son of Dr. P. Manson, chief medical officer of the Colonial Office, is expected to follow Dr. Durham in about two months. A stay will be made on Christmas Island, and the mission will then proceed to visit some of the Polynesian Islands to make pathological investigations. It is expected that these inquiries will extend over a year or eighteen months.

### Explosion in a Laboratory.

A SERIOUS accident has occurred at the Cambridge Chemical Laboratory to Mr. W. T. N. Spivey, M.A., of Trinity College, Demonstrator to the Jacksonian Professor of Natural Experimental Philosophy. Mr. Spivey was doing some research work, and from the nature of his injuries it seems that he was shaking the contents of a flask when it exploded. He was severely burnt under his arm and on his chest and back, and his arm was severely cut with the broken pieces of glass. The flask in which the experiment was being made was uncorked at the time, and the cause of the explosion is inexplicable.

### Shorthand for Medical Students and Practitioners.

AMONG the students who have just commenced their medical studies there are probably some who are acquainted with shorthand, having learnt it at school. The attention of such students is specially invited to the Society of Medical Phonographers. The object of this Society is to increase the practical service of shorthand to its members by publishing a monthly periodical and other shorthand medical works. Also, any medical practitioners who use shorthand and have not yet joined the Society are cordially invited to do so. No skill in shorthand is necessary for membership. The annual subscription for students is 5s.; for practitioners, 7s. 6d. A detailed prospectus of the Society will be sent on application to the hon. sec., Dr. Fletcher Beach, 79, Wimpole Street, W.

### The Local Government Board Report (1900).

AMONG other items of interest, the Annual Report of the Local Government Board gives some startling figures bearing on the working of the Vaccination Act of 1898, under which compulsion was abolished on condition of a statutory declaration of “conscientious objection.” Twelve years ago the return showed that of

903,846 children born 754,059 were successfully vaccinated. We now learn that of 923,059 children born in 1898 only 562,737 have been vaccinated. People do not even take the trouble to make the “conscientious” declarations; being alive, it may be, to the farcical character of a procedure which provided for the infliction of a fine, not for non-compliance with the law, but for failure to make a representation to petty sessions as to the condition of his “conscience.” In London little more than half the children born in 1898 were vaccinated, and in particular unions, such as Shoreditch, Mile End, Bethnal Green, and Poplar, the proportion of vaccinated children was quite insignificant. So, too, in certain parts of the provinces. In Bedfordshire there were 4,201 births, but only 626 vaccinations. In Leicestershire there were 12,878 births, but only 1,228 vaccinations. On the other hand, in many rural districts, and even in a few large towns like Liverpool, Birkenhead, Kidderminster, and Portsmouth, the local authorities manage to get nearly all the children vaccinated without much difficulty. But the outlook generally is disquieting, especially in London, having repeatedly been a prey to small-pox in the past, seems to be now receiving unvaccinated additions to its population at the rate of over 40,000 a year. If this goes on there will soon be a tolerably wide field for the epidemic which has for some time been threatening.

### Medical Sickness and Accident Society.

THE usual monthly meeting of the Executive Committee of the Medical Sickness Annuity and Life Assurance Society was held at 429, Strand, London, W.C., on 27th ult. There were present—Dr. de Havilland Hall (in the chair), Dr. G. E. Herman, Dr. J. B. Ball, Dr. Walter Smith, Mr. H. P. Symonds, Dr. M. Greenwood, Mr. J. Brindley James, Dr. St. Clair B. Shadwell, Mr. F. S. Edwards, Dr. F. J. Allan, Dr. J. W. Hunt, Dr. Alfred S. Gubb, and Dr. Frederick S. Palmer. The accounts presented showed that the claims experience of the summer months had been light, as, although the number of claims received had been about the same as usual, few cases had been of a severe nature and of long duration. A considerable addition has therefore been made to the funds, which now amount to over £150,000. Of this a substantial amount is required to secure the liberal provision made by the society to those of its members who become permanently incapacitated. The amount allowed is usually one hundred guineas a year, and nearly twenty members will probably draw this annuity until they reach sixty-five, or till death before that age. Prospectuses and all particulars on application to Mr. F. Addiscott, Secretary, Medical Sickness and Accident Society, 33, Chancery Lane, London, W.C.

### Society for Relief of Widows and Orphans of Medical Men.

A QUARTERLY Court of the Directors was held on Wednesday, October 9th, Mr. Christopher Heath, President, being in the Chair. Two new members were elected, and the death of a member reported. There were no fresh applications for grants. The death of a widow was announced, who had been in receipt of grants since 1882, and had received £1,084 10s. from the society, her husband having paid £28 as subscriptions. Applications for renewal of grants were read from fifty-one widows, thirteen orphans, and five recipients from Copeland Fund, and it was resolved that £1,168 be distributed among them at the next Court. It was determined to make a Christmas present to the widows and orphans on the fund, the amount £569 to be divided among them, thus disposing of the surplus income. The expenses of the quarter were £86.

### Society of Apothecaries of London.

THE following candidates have passed the Primary Examination, Part I.:—Biology: J. C. Fletcher. Chemistry: H. W. Phillips. Materia Medica and Pharmacy: G. C. M. Davies, A. B. Gosse, G. H. Henry, P. S. Hopkins.

Primary Examination, Part II.—Anatomy and Physiology: R. S. Dollard, G. H. Henry, A. C. Jenkins, J. D. Staley. Physiology only: H. Bennett, P. J. Martin, J. O. Sergeant, D. A. Stepney, E. J. S. Verity.

## Notices to Correspondents, Short Letters, &c.

**CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *distinctive signature* or initials, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

**ORIGINAL ARTICLES** or **LETTERS** intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication, but as evidence of identity.

### SOME MEDICAL APHORISMS.

1. Life is short, patients are fastidious, and the brethren deceptive.
  2. Practice is a field of which tact is the manure.
  3. Patients are comparable to flannel—neither can be quitted without danger.
  4. The physician who absents himself runs the same risk as the lover who leaves his mistress; he is pretty sure to find himself supplanted.
  5. Would you rid yourself of a tiresome patient, present your bill.
  6. The patient who pays his attendant is but exacting: he who does not is a despot.
  7. The physician who depends upon the gratitude of his patient for his fee is like the traveller who waited upon the bank of a river until it would finish flowing that he might cross to the other side.
  8. Remember always to appear to do something—above all when you are doing nothing.
  9. With equal, and even inferior, talent, the cleanly and genteelly-dressed physician has a great advantage over the untidy one.—*Dietetic and Hygienic Gazette.*
- DR. J. W. MARTIN.**—Your letter is unavoidably crowded out.
- QUEERNS.**—The Wolfe-Krause method of skin grafting consists in taking pieces of the entire thickness of the skin and transplanting them to the part to be grafted.
- A **CORRESPONDENT** calls our attention to the fact that the man Cubbin, *alias* Robert Wilson, who, in the police reports, is described as a medical practitioner, has no sort of right to that honourable title beyond the fact that he was fined at Garstang in 1900, at the instance of the Medical Defence Union, for falsely representing himself to be a registered medical practitioner.
- DR. F. C. FITZGERALD** (Newtownbutler).—We regret that we are unable to accede to your request.
- CLEMENT H. SEES.**—Your letter will appear in our next.
- MR. LIVERIDGE.**—The mortality from typhoid fever in this country is about 15 per cent.

## Meetings of the Societies.

WEDNESDAY, OCT. 16TH.

**CENTRAL LONDON THROAT, NOSE, AND EAR HOSPITAL** (Gray's Inn Road, W.C.).—8 p.m. Introductory Lecture.—Mr. L. Browne: The Relationship to General Medicine of the Special Diseases treated at the Hospital, also to other Diseases constituting separate Specialisms.

THURSDAY, OCT. 17TH.

**HARVEIAN SOCIETY OF LONDON** (Stafford Rooms, Titchborne Street, Edgware Road, W.).—8.30 p.m. Paper:—Mr. C. Williams: Hæmaturia in Childhood.

**OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.**—8 p.m. Cases.—Mr. R. Marcus Gunn: Persistent Double Keratitis, mainly superficial, without Tendency to Ulceration. Mr. S. Stephenson: A Case of Congenital Distichiasis. Mr. E. T. Collins: A Case in which Mooren's Rodent Ulcer had six years previously involved the Whole Surface of Kach Cornea. Mr. N. B. Harman: Choroidal Angio-Sclerosis, and Paralysis of Third Nerve with Unusual Symptoms. Presidential Address:—Some Clinical Experiences of Primary Chronic Glaucoma and the Value of Iridectomy. Papers:—Mr. S. J. Taylor: Notes of a Case of Rodent Ulcer of the Cornea in a Child. Mr. E. Nettleship: Chronic Serpiginous Ulcer of Cornea (Mooren's Ulcer).

FRIDAY, OCT. 18TH.

**SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.**—5.30 p.m. Cases:—Dr. Garrod (introduced): A Case of Spastic Paraplegia with Ataxy and Eritematous Pigmentosa; Urine from Cases of Alkaptonuria. Mr. H. S. Collier (introduced): A Case of Necrosis of the Frontal Bone; A Case of Laryngeal Stenosis. Dr. D. B. Lees: A Case of Rheumatic Heart, Recovery from Brachial Thrombosis; A Case of Apysemic Neuritis caused by Liquor Arsenicalis; A Case with Large Nodules, Recovery. Dr. Hutchison: A Case of Double Facial Paralysis from Middle Ear Disease; Cases showing Congenital Abnormalities. Paper.—Dr. Chaffey: A Case of Diffuse Lymphoma, terminating in Pernicious Anæmia, in an Infant. Specimens.—Dr. Theodore Fisher: Congenital Mitral Stenosis from a child, aged fifteen months; Congenital Aortic Stenosis from a child aged four months.

MONDAY, OCT. 22ND.

**ODONTOLOGICAL SOCIETY OF GREAT BRITAIN.**—8 p.m. The President will deliver his Inaugural Address. Communications will be given by Mr. F. C. Wallis on "Misplaced, Unruptured Wisdom Teeth treated by External Operation." Mr. J. G. Turner on "The Teeth of Cretins and Microcephalics." The President and Mr. Lewin Payne: "Notes on the Dentition of Sphenodon."

## Appointments.

**BONNEY, W. F. VICTOR, M.D., M.S.Lond., F.R.C.S.Eng.,** Physician to Out-Patients, Chelsea Hospital for Women.

**BYFORD, W. F., M.B.C.S.Eng., L.R.C.P.Lond.,** Medical Officer of Health of the Borough of Bathin.

**COUTTS, F. J. H., M.D.Vict., D.P.H.,** Medical Officer of Health of the Borough of Blackpool.

**DOBBS, K. D. B., L.R.C.P., L.R.C.S.Irel.,** Medical Officer of Health of Turbury.

**GRIFFITHS, A. F., M.D.Harvard,** Clinical Assistant, Chelsea Hospital for Women.

**LEHMANN, J. E., M.B.Toronto, L.R.C.P., M.B.C.S.,** Assistant Surgeon to the German Hospital, London.

**MARSHALL, LEIGH-RICHMOND, L.S.A.Lond.,** Medical Officer and Public Vaccinator to the Mary Tavy District of the Tavistock Union.

**MCCARDEL, E. J., M.D., Ch.M., M.B.C.S.Eng.,** Clinical Assistant, Chelsea Hospital for Women.

**SHERREY, JAMES, F.R.C.S.Eng.,** Surgical Registrar to the London Hospital.

**VON MURALT, WILLY, M.D.Zurich,** Clinical Assistant, Chelsea Hospital for Women.

**WADDINGTON, W. HETWOOD, M.B.Vict., L.S.A.,** Medical Officer of Health for Scarborough.

**WHITEHOUSE, W. H., M.D.Durh., D.P.H.,** Honorary Medical Officer to the Birmingham Lying-in Charity.

**WILLIAMS, LEONARD, M.D.Glasg.,** Assistant Physician to the German Hospital, London.

## Vacancies.

**Belfast, Royal Victoria Hospital.**—Medical Superintendent. Salary commencing at £300 per annum, with board and residence. Applications to the Hon. Sec. (See Advt.)

**Birmingham General Dispensary.**—Resident Surgeon, unmarried. Salary £150 per annum, with rooms, fire, lights and attendance.

**Bristol General Hospital.**—Assistant House Surgeon. Salary £70 per annum, with board, residence, &c. Applications to the Secretary.

**Chelsea Hospital for Women, Fulham Road, S.W.**—Registrar. Honorarium, 20 guineas per annum.

**City Asylum, Birmingham.**—Junior Assistant Medical Officer, unmarried. Salary £150 a year, with board, apartments, and washing.

**Cornwall County Asylum, Bodmin.**—Junior Assistant Medical Officer, unmarried. Salary £120, rising to £150, with board, apartments, laundry, &c.

**Denbighshire Infirmary, Denbigh.**—House Surgeon. Preference given to one having a knowledge of the Welsh language. Salary £100 to commence, with board, residence, and washing. Applications to the Secretary.

**Essex County Asylum, Brentwood.**—Junior Assistant Medical Officer. Salary £140 per annum. Apply to the Medical Superintendent.

**Hospital for Women, Soho Square, W.**—Assistant Physician.

**Ingham Infirmary.**—Senior House Surgeon wanted. Salary £100 per annum, with residence, board, and washing. Applications to the Secretary, 74, King Street, South Shields.

**Manchester Monnal Fever Hospital.**—First Medical Officer. Salary £150 per annum, with board and lodging.

**Middlesex Hospital, W.**—Honorary Physician.

**Morpeth Dispensary.**—House Surgeon, unmarried. Salary £120 per annum, with rooms, coals, gas, and attendance.

**Plymouth Borough Asylum.**—Assistant Medical Officer, unmarried. Salary £150 per annum, rising to £200, with apartments, board, and washing.

**Royal National Hospital for Consumption and Diseases of the Chest, Ventnor.**—Resident Medical Officer, unmarried. Salary £150 per annum, with board and lodging.

**West Riding Asylum, Wakefield.**—Locum Tenens for three months from Nov. 1st next. Salary £3 3s. a week, with apartments and board.

**York County Hospital.**—House Surgeon. Salary £100 per annum, with board, residence, and washing.

## Births.

**FOULDS.**—On Oct. 8th at Ashlea, Droitwich, the wife of Francis H. Foulds, M.B.C.S., L.R.C.P.Lond., of a daughter.

## Marriages.

**COOPER-FERGUSON.**—On Oct. 10th, at the Presbyterian Church, Cardiff, by the Rev. Alexander Macmillan, W. Herbert Cooper, M.B.C.S.Eng., L.R.C.P.Lond., of Staveley, Westmoreland, son of Astley Cooper, Dep. Insp.-Gen. R.N., of Exmouth, Devon, to Mabel Kate, second daughter of John Fergusson of Cardiff.

**JONES-WATTS.**—On Oct. 10th, at St. Mary Abbot's, Kensington, by the Vicar, the Rev. Canon Pennefather, Walter Paul Jones, M.D., of 1, Walton Place, Hans Road, S.W., second son of William Harry Jones, of Castelnau House, Barnes, to Georgiana Frances, elder daughter of George Nelson Watts, of "Woodcote," Castelnau, Barnes.

## Deaths.

**DICKINSON.**—On Oct. 10th, at 2, Grove Park, Liverpool, in his 59th year, Edward Harrin in Dickson, M.D., F.R.C.P.

**THOMSON.**—On Oct. 6th, at Beechhurst, Camberley, Surrey, Surgeon-Major-General William Arthur Thomson, Honorary Physician to the King, aged 71.

# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXIII.

WEDNESDAY, OCTOBER 23, 1901.

No. 17.

## Original Communications.

### HÆMATURIA IN CHILDHOOD. (a)

By CAMPBELL WILLIAMS, F.R.C.S.

MR. PRESIDENT AND GENTLEMEN.—The subject of my paper this evening is one with which most medical men are from time to time brought in contact. Frequently the anxious parents expect a decided opinion on, so to speak, the spur of the moment, not only as to its aetiology and source, but also as to the prognosis. In many cases, owing to obvious corroborative signs, or assisted by the incontestable presence of disease with which hæmaturia is apt to be associated, it may be possible to answer their queries off-hand, not only as to the cause, but also, judging from the appearance of the urine, as to the source of the blood. In certain instances, even with constant observation, and after the kindly assistance of the sound, microscope, skiagraph, and cystoscope, if it can be introduced, there may be considerable difficulty in making up one's mind, if not as to the source of the hæmorrhage, at least as to the cause thereof. One is sometimes able to diagnose, by watching the patient pass water into a glass beaker, as to whether the blood proceeds from the urethra, the bladder, or kidneys. Again, the character of the blood or clots in the voided urine may give a fairly accurate clue as to the site of origin. But this is not always so. The classical naked eye appearance of urine impregnated with blood from the kidneys is described as varying from a smoky tint up to the colour of dark porter. Whenever one meets urine of this nature there can be no doubt as to its renal origin. But it must be remembered that when there is copious renal hæmorrhage, which is not in the category of congestive relief, for instance, as in tuberculosis or with sarcomatous implication, that the macroscopic picture of the extruded kidney blood may closely simulate the appearance usual to a vesical or even an urethral source. Hæmaturia may depend either upon purely local causes, or it may form but one symptom of some general systemic disorder. It is seen in the department of the physician as an attribute of many of the complaints of infancy or childhood. Thus, it is met in conjunction with rickets, infantile scurvy, and hæmophilia. Or the hæmorrhage may be associated with anæmia, with or without tuberculosis, purpura, Raynaud's disease. Again it occurs in connection with renal infarction, pneumonia, acute nephritis typhus, variola, malaria, diphtheria, and scarlet fever. It is sometimes due to the presence of the bilharzia hæmatobia, either in the pelvis of the kidney or in the vesical veins. Another parasitic cause is the flarua sanguinis hominis, or it may result from the intravesical presence of migratory intestinal worms. The administration of such drugs as chlorate of potash, cantharides, or turpentine may be the provocative cause. It is also stated to have been sequent to the administration of piperazine and urotropine. I have seen a case where the appearance of hæmaturia was ascribed as secondary to heavy doses of boracic acid. I have purposely excluded reference to

paroxysmal hæminglobinuria, Winkle's disease, and other blood dyscrasie, for the obvious reason that they are not corpuscular, but rather of a pigmentary nature, and should be regarded as hæmatinuric.

The domain of surgery is also prolific in causes, and it is to the consideration of these to which this paper is intended. If at times I trench upon the medical aspect of the subject I must claim as my excuse that it is absolutely imperative for the surgeon to review cases of hæmaturia, not only from his special standpoint, but also from that of the physician. Hæmaturia may result from traumatism of any portion of the urinary tract, or it may be due to the presence of a renal, uretal, vesical, or urethral calculus. It is likewise a symptom of tubercle or sarcoma of the kidney or bladder. Rarely the blood may be extruded from a villous vesical growth, mucous polyp, or from an urethral caruncle. It is sometimes an accompaniment of oxaluria, or it is consequent upon the excretion of highly acid urine. Cystitis is also a factor in its production. Its presence has been ascribed to phimosis, in that the effort of the contracting viscus to overcome obstruction induces an hyperæmic condition of the vesical mucous membrane. Personally, I have never met with it dependent on phimosis alone. Mention must also be made of foreign bodies that have been introduced within the bladder from without. Occasionally one meets with cases in which the child, though suffering from a moderate amount of hæmaturia, displays nothing definitely wrong with the general health, or otherwise to account for the phenomenon. In the few cases that I have seen of this nature the bleeding has undoubtedly been of vesical origin. This can be gauged by the glass test. The first portion of the urine passed is, to the naked eye, quite clear; but as the bladder empties itself, and consequently the muscular contraction becomes more pronounced, the appearance of blood is noted and can be seen to increase in quantity with the *scale* of the act of micturition, being as it were extruded from the mucous membrane just as water is squeezed from a sponge.

*Traumatism.*—In cases of hæmaturia of traumatic origin there are usually the external signs of injury to guide one as to the probable source of the hæmorrhage. It may be that there is the mark of the wheel, or perchance the discovery of a fractured pelvis or rib gives a clue to the damage that has occurred within. Take the case of a child who has been run over by a vehicle. The amount and persistency of the shock, together with the degree of the bleeding, may also afford some light in cases of intra-abdominal injury, such as rupture of the kidney, ureter, or bladder. The subsequent mode of passage of clots in the urine has a certain diagnostic value. For instance, a long clot which passes after the commencement of a voluntary urination would infer that it was not formed in the *urethra*, otherwise it would have been expelled at the very start of micturition. Its contour suggests formation in the *ureter* prior to its descent into the bladder, and would be strong presumptive evidence that it was either the resultant of an *uretal* laceration or that it had been moulded in the tube by blood trickling down, and subsequently coagulating, from a contused or ruptured kidney. These clots are somewhat similar in shape to those formed in the penile urethra when that has been injured. In the latter

(a) Read before the Harveian Society, October 17th, 1901.

case the hæmaturia is due, if it be present at all, to the reflux of blood into the bladder. In a recent case of *urethral* injury there is usually a more or less continuous oozing of blood from the penis, either independent of the act of micturition or which persists after the bladder has emptied itself. In renal injury, particularly laceration, the hæmorrhage may be very profuse, so that the bladder may be fully distended by coagulated blood, which imperatively demands removal. In rupture of the kidney the shock is necessarily pronounced. A certain amount is traceable to contusion of the sympathetic plexus. But if the prostration be of a gradually deepening character, and out of proportion to the amount of visible hæmaturia, it is strongly suggestive of some additional and progressive retro- or intraperitoneal hæmorrhage. It must be borne in mind that the renal lesion and its concomitant hæmaturia may form but a portion of the abdominal damage, and that there may be equally grave injury to other organs. In cases of traumatism of the ureter the amount of blood voided varies in relation to the nature of the injury. By this I mean whether the tube is simply contused or torn. The diagnosis of this condition, though suspected, is exceedingly uncertain. Should, however, the patient survive, obliteration of the uretal lumen supervenes when it has been lacerated, as evidenced by the appearance of an hydronephrosis, a condition which calls for nephrectomy. I well remember a case of this kind, a little girl who had been run over, and was admitted into University College Hospital under the late Berkeley Hill. A large hydronephrosis rapidly followed the injury. Vesical hæmaturia, the result of direct violence, may be sequent to penetrating wounds of the perineum, rectum, or abdomen which reach the bladder. The escape of blood-stained urine from the wound would disclose the nature of the mischief. If the hæmaturic state be due to internal laceration, without external breach of surface, such as occurs from displaced fragments of the pelvic bones, it will be disclosed, if it has not already revealed itself, on the passage of a catheter. This procedure is in accordance with the fundamental law of systematic examination in abdominal injuries.

In cases of rupture of the bladder the contents usually escape within the abdominal cavity, except in those rare instances where restraint has been exercised by a more or less intact peritoneal covering. The collapsed viscus is found to be practically empty, and unless the instrument happens to be guided through the rent, so that the extravasated urine is reached and tapped, there is very little bloody fluid drawn off. These cases are fortunately rare, owing perchance to the greater mobility of the bladder, from its position, in childhood. Shock is profound, and the issue, notwithstanding surgical interference, when permissible, is usually fatal, either directly from the injury or from subsequent peritonitis. As regards operative measures, every case must be judged on its own merits. Surgical instinct would, in view of the highly probable lethal results of non-interference, impel one to run the risk of the superimposed shock of an operation for stitching up the rent in the bladder, combined with continuous urethral drainage of the secreting urine.

The symptoms, causes and treatment of rupture of the urethra in children differ in no way from a like condition in the adult, except that the accident is of rarer occurrence, possibly owing to the falling weight of a child's body being less than that of a grown-up person, and consequently the force of impact is proportionately decreased. Moreover, the infantile or immature urethra is undoubtedly more elastic and compressible.

*Calculi.*—The presence of a calculus in the pelvis of the kidney, ureter, or bladder may give rise to hæmaturia, in addition to other significant signs. In cases of impacted stone of the urethra, causing either total or partial obstruction to vesical outflow, there may or may not be a certain amount of bloody urine passed or drawn off after the extraction or repression of the calculus. Such, however, as is present is caused either by a regurgitation of penile blood or arises from some laceration occasioned by pushing the stone back into the bladder. Hæmorrhage is more consistently met with, in my experience, as a diagnostic sign of calculus met in connection with

the kidney and ureter rather than with the bladder; more particularly so, if the stone be of the rough, mulberry, or oxalate of lime variety. In a great number of cases of vesical calculus the only symptoms may be painful and *infrequent* micturition. This is apparently due to the child refraining from passing water as long as possible owing to the attendant pain. Frequency of micturition is met with in older children or when cystitis has supervened. It is more often one of the signs of stone in the renal pelvis. The explanation probably is that in these cases its presence stimulates secretion, and since evacuation of the bladder does not cause pain, but rather relief, micturition is unhesitatingly resorted to. I have been struck by the fact that the symptom of hæmaturia is absent in many cases of proved vesical calculus, and that the chief diagnostic signs have been dysuria and *infrequent* urination. In the case of a baby boy, *æt.* 18 months, from whom a stone was removed by Mr. Pickering Pick, the only symptoms were pain and restraint. It was at first thought to be due to a tight congenital phimosis. But as the painful micturition continued after circumcision I sounded him and found this stone. The naked eye appearance of urine impregnated with blood from a renal or uretal source is one of equal and intimate diffusion. By this I mean that the last ounce passed during an individual micturition is of the same hue as the first drops. Not as in some cases of vesical hæmaturia wherein the blood appears as a rosy tint and increases to a bright scarlet as the bladder empties and compresses the hyperæmic or, perchance, excoriated mucous membrane upon the stone. The colour of renally extruded blood varies considerably. This depends partly on source, the causation, the amount, and the chemical action of the constituents of the urine on the hæmatin. Thus it may range from a smoky up to a dark porter tint, or it may give a rosy or red appearance to the urine. Broadly speaking, the smoky and darker colours are indicative of a central origin, with escape through the uriniferous tubules, whilst the brighter ones have a more superficial birth-place in the actual or immediate vicinity of the renal pelvis. Until comparatively recently the diagnosis of calculi was dependent upon clinical evidence, needling, sounding, or the sense of touch. Now the assistance of the skiagraph renders positive, by photography, what was frequently a matter of differential and uncertain diagnosis. In renal cases it is of the greatest possible value and serves to eliminate all doubt as to the presence or absence of a stone and, moreover, as to its situation. If a child cannot be made to understand the necessity for lying still during skiagraphy, then resource must be had to an anæsthetic to keep it quiet for the few seconds required for the undertaking.

Sarcoma is the type of malignant disease which affects the urinary organs in infancy and childhood. In infantile life the kidney is practically exclusively involved, but with advancing years the bladder becomes less liable to exemption. In certain instances the disease is undoubtedly congenital and of a myo sarcomatous nature. As an *acquired* condition it is most commonly met with during the first seven years of life. In the majority of cases attention is drawn to the state of affairs by the appearance and rapid development of an abdominal swelling. In others it is the hæmaturia which causes alarm. The invasion of renal sarcoma is sometimes marked by the advent of precocious puberty. The tumour growth is rapid and secondary infection occurs early. For this reason, quite apart from the fact that abdominal major operations are badly borne by children the prognosis of a nephrectomy is most gloomy. Recurrence invariably ensues in those that survive operative measures. Hæmaturia may appear quite early in renal sarcoma, but more frequently its presence is delayed until the disease is far advanced or it may remain absent throughout the case. The structure of the growth and its relation to the pelvis of the kidney are probably the determining factors of influence. By this I mean the histological composition and its situation, whether it is encapsuled or the reverse, and whether it arises as a perinephritic or interstitial infiltration. The outlook of vesical sarcoma is



equally bad, and the condition causes more distress to the patient. Hæmaturia is a more constant phenomenon. In these cases there is the superadded pain, caused by the periodic compression of the growth by the contracting bladder. The amount of blood lost is frequently severe and progressive, and occurs with each micturition, so that the sufferer is soon worn out. Cystotomy may have to be employed, either as a diagnostic or palliative measure, to clear out clots or to relieve pain and cystitis. One would be guided as to whether a median perineal or a suprapubic incision should be made, by the probable site of the growth as disclosed by rectal and abdominal examination.

Papilloma, or villous tumour of the bladder, is an exceedingly rare occurrence in childhood. In fact, it may be said, if we exclude sarcoma, that the bladder is not liable to tumour formation during the early years of life. Consequently, a mucous polyp or an adenomatous growth, when met with, will probably form the solitary experience of a life-time. In the case of villous tumour the cause of the hæmaturia would be revealed by microscopical detection of a detached epithelial fragment, or, if the urethral lumen permitted, by cystoscopic examination. Urethral caruncle is also a condition rarely seen. It only affects female children. I had a case in a girl, *æt.* 8. The little growth was situated on the floor of the urethral orifice. It was about the size of a No. 5 shot. Whether it arose from a former strumous vaginitis I cannot say.

Tubercle is a frequent cause of hæmaturia. Usually this is directly dependent upon tuberculous invasion of some portion of the urinary tract. Occasionally it appears to be indirect as the result of anæmia consequent upon distal tuberculosis without there being any definite evidence of a local lesion. The hæmorrhage seems to be of a passive nature similar to what is met with in conjunction with anæmia, hæmophilia rickets, or scurvy. The bleeding in these cases seems to be of vesical origin. It is of moderate amount and is usually discovered accidentally as it causes no inconvenience. It is also transient, subsiding either of its own accord or under appropriate treatment. In this it differs markedly from the hæmaturia due to local tuberculous foci, which has a progressive tendency to get worse, with the appearance sooner or later of pus in the urine. In the majority of cases of urinary tuberculosis pus precedes the advent of blood, or at least is discovered synchronously with it. Occasionally hæmaturia is the first noticed sign, at least in renal if not in vesical tuberculosis. With a tuberculous pyelitis one finds what one would expect, namely, pus primarily to blood. But with an initial implication of the body of the organ, a central deposit, one may get hæmaturia preceding the pyo-uria. The blood in these cases is intimately mixed with the urine, which is of uniform colour. If, however, the bleeding has been severe some clots may be discovered. The bacillus is usually to be found in the pus cells, or its existence can be gauged by experimental methods which would confirm the indications of a carefully kept temperature chart. Tubercle of the bladder when it has proceeded to ulceration may be the cause of severe hæmorrhage, so that a clot may be formed which fills up the entire cavity and requires removal, for the distension causes great agony. When the bladder is the chief seat of the tuberculous infection, which is often widely spread rather than restricted to one particular organ, it will be seen that the character of an individual micturition varies as to the amount of blood passed. This is not constant. Sometimes there is comparatively little lost, and then the following act of micturition will contain a considerable volume. In fact a severe hæmorrhage is sometimes followed by a quantitative respite of bleeding, probably owing to enfeebled circulation or to clot blocking of the patient vessel. In vesical hæmaturia the last drops voided are of a brighter colour than those at the commencement of urination. Should the rudimentary prostate be involved pure blood usually follows the *finale* of the act. The question of treatment of vesical tuberculosis by local means resolves itself into whether you shall proceed to operative measures—open the bladder, scrape the ulcers, and give rest to the organ by

drainage, or whether one shall treat the intact viscus with irrigations and the injection of iodoform emulsion. Usually the latter method is tried first. Sometimes it succeeds, but more often it fails either to check the hæmaturia or to ameliorate the existing cause thereof. Suprapubic cystotomy does hold out some hope of, anyhow, local benefit. I have had personal experience of two cases in adults whose bladders got quite well after operation.

Hæmaturia is occasionally met with in ricketty subjects, but personally I have only seen it associated with the acute form of the disease—scurvy rickets, or, as it is called, infantile scurvy. In these cases the bleeding is most frequently of renal origin, and forms but one of kindred exudations from various mucous surfaces. The hæmorrhagic gums, epiphyseal enlargements with perchance subperiosteal extravasations and pseudo paralysis of the affected limb, either due to tension from effusion or to pain, would materially go towards forming the diagnosis. In hæmophilia the hæmaturia may be the first evidence of the existence of the condition. In such a case the only method of diagnosis would be one of exclusion, bearing in mind the sex of the patient, together with a history of a similar diathesis in other members of the family. But too much reliance cannot be placed upon this, for although hæmophilia is apt to attack, if not all, anyway a large percentage of the males of a family, nevertheless it sometimes excludes certain of them, so that it may be confined to only one member thereof. If, however, there was a suspicion that slight scratches in this particular child had been followed by persistent oozing then a hint might be gleaned as to the true nature of the case. In these cases chloride of calcium in five grain doses, frequently repeated, has been of great service. Of more recent date is the treatment of the condition by supra-renal extract. This is used locally as a styptic lotion 5 per cent., and is also administered internally in two to five grain doses, a careful watch being kept for cardiac phenomena. Blood in the urine sometimes proceeds from an excoriated meatus urinarius. The stinging produced by the acid urine passing over the raw spot causes the child to cry—this draws attention to the urine. Blood is discovered and advice is then sought for the infant in the belief that there is something more serious the matter than this simple condition. If any doubt be entertained as to the presence of blood in the urine resort can be had to microscopical examination or to spectrum analysis. When blood is present, even in infinitesimal quantity it shows absorption lines in the yellow and green of the spectrum, between D and E (Fraunhofer's lines). The most usual chemical test, though open to fallacy, is to add a few drops of tincture of guaiacum to a little urine, and then to pour in an excess of ozonic ether. This is ether containing in solution peroxide of hydrogen of thirty volume strength with some alcohol. If blood be present, a bright blue colour appears, due to the oxidation of the guaiacum by the ether through the presence of the hæmoglobin.

## THE ASPHYXIAL FACTOR

IN

### NITROUS OXIDE ANÆSTHESIA.<sup>(a)</sup>

By T. PERCY C. KIRKPATRICK, M.D.,

Anæsthetist, Dental Hospital, Ireland.

GENTLEMEN,—I propose to bring before you some points in connection with the administration of anæsthetics, but before doing so I wish most seriously to impress on you the importance of the subject. If you propose in your practice undertaking the administration of these drugs, or merely operating on patients while under their influence, it is your bounden duty to make yourselves thoroughly conversant with the methods of their administration, with the dangers attendant on it, and with the means which are at your disposal for meet-

(a) Being a Paper read at the Opening Meeting of the Dental Students' Society of Ireland, October 9th, 1901.

ing these. It is, I fear, commonly thought that the administration of an anæsthetic is nothing, merely a means to an end—the abolition of pain—and familiarity breeds contempt. If, however, you wish to become good anæsthetists, to do the best for the patients who submit themselves to your care, you must get completely rid of this idea and recognise that, in the majority at all events of surgical operations, the patient runs a greater risk from the anæsthetic than from the operation. In the administration of an anæsthetic you abolish for the time many of the vital functions of your patient by means of a powerful nerve poison, and the margin between the loss of these and the loss of those which are essential to life is by no means wide. If you thoroughly grasp this idea and, acting on it devote to your patient your full care and attention, you go a very long way towards the avoidance of the many dangers which beset this important branch of practice. It is hardly possible for the operator to give that attention to the patient which the administration demands, and hence the reason why most men now prefer to share the responsibility with a doctor.

I believe that it will be more useful to you if I direct your attention tonight to one or two problems which present themselves to the anæsthetist rather than give you a general dissertation on the subject, and as I suppose you are more likely to be interested in the administration of nitrous oxide than of any other anæsthetic I shall confine my remarks chiefly to it.

As you are all doubtless aware, Sir Humphrey Davy first discovered nitrous oxide gas in 1799, but it was not till the year 1844 that it was first practically made use of in surgery, when Horace Wells, an American dentist, performed the first dental operation quite painlessly on a patient who was under its influence. It was not till twenty years later (1863) that its use became at all general, but since that time it has fairly held its own as the safest and, for short operations, by far the most convenient anæsthetic.

Although the anæsthetic properties of the drug were thus early discovered its true physiological action, and consequently the proper methods for its administration, were not known till after the classical researches of Paul Bert in 1878, and even yet, to judge by the methods which one commonly sees adopted, they are not at all fully appreciated. The great stumbling block in the way of nitrous oxide as an anæsthetic was the asphyxia which attended its use and which was considered essential to it. Even within my own memory it was commonly taught that the exclusion of air, absolutely and completely, was of the first necessity in the proper administration of gas. Now this is the point which I wish to draw your attention to-night, for there is not the slightest doubt that when accidents arise from the use of this drug in the great majority of cases they are due to the asphyxia which is associated with it. This being so, if we can abolish altogether the asphyxial element, or at all events keep it well under our control, we shall at the same time abolish most of the danger attendant on its use, and here most truly prevention is better than cure. If then you wish to properly control the asphyxial element, which is quite unessential to good gas anæsthesia as is shown by the use of nitrous oxide and oxygen, you must have a clear idea of the symptoms and signs of its onset, of its physiological and pathological relationships and the indications which they afford for its treatment.

Asphyxia may be defined as that condition into which an animal passes when for any reason the due oxygenation of its blood is interfered with. The condition is the result of the want of oxygen rather than due to the accumulation of  $\text{CO}_2$  in the blood, for such an accumulation in the presence of a sufficiency of oxygen acts as a narcotic poison not unlike nitrous oxide itself. This, then, is the cardinal point which you must bear in mind, asphyxial phenomena are the expression of the want of oxygen by the organism and the indication for treatment is clear and definite, supply oxygen, or what is the same thing, atmospheric air.

When the supply of oxygen is completely cut off from an animal the condition of asphyxia develops, and the symptoms which it presents are usually grouped into three stages as follows:—

1. Stage of exaggerated breathing or hyperpnœa, as it is called. The respirations are increased in frequency and depth, the inspirations being at first particularly prolonged and exaggerated. The respiration is accompanied by a distinctly audible sound, the lips get blue, the eyes prominent, and the blood pressure begins to rise. This stage lasts for about a minute or longer, according to whether the deprivation is gradual or sudden and complete, and gradually passes into the second stage, the chief characteristics of which are dyspnœa or difficulty of breathing and convulsions. All the symptoms of the former stage become more marked, and soon the respirations become convulsive while the other muscles of the body are thrown into a state of clonic convulsions, or what in gas anæsthesia is known as jactitation. This stage is slightly shorter than the preceding one, and the blood pressure continues to rise considerably while the cyanosis becomes very marked.

The third stage of exhaustion follows, the spasms give way, the muscles becoming relaxed, and the patient is insensible, with widely dilated pupils. The blood pressure now falls rapidly below normal, and the pulse is scarcely perceptible, paralysis of the respiratory centre takes place, and death ends matters. If the heart be examined at once after death it is found that the right side with the pulmonary arteries and systemic veins are gorged with dark-coloured blood, while the left side of the heart is empty, as are also the pulmonary veins and systemic arteries. Small hæmorrhages may be found under the serous membranes.

This, then, is a picture of asphyxia, one which fortunately we seldom see in its entirety, but which in parts is common enough in gas anæsthesia, how often you will recognise if you compare with it the anæsthesia of nitrous oxide and oxygen, though the only difference between the two is the admission of oxygen in the latter, and its exclusion in the former. When oxygen is administered with the gas we get an anæsthesia characterised by a quiet sleep-like breathing, with a natural colour, quiet pulse, relaxed muscles, fixed eyeballs, and normal pupils. When you have fully grasped the difference between these two conditions and recognise that this difference is due simply to the admission or deprivation of oxygen you will be in a better position to appreciate the signs of asphyxia, even in the slightest degree, and so either avoid it altogether or keep it properly under your control. When you are able to do this you will be able to avoid what is by far the commonest cause of all the accidents and untoward circumstances which are likely to arise from the administration, not only of nitrous oxide, but also of ether and chloroform. Your anæsthesia will in every case be better, and should any accident arise your patient will be in a far better position to meet it than would be the case were the asphyxial factor also added to the danger.

Let me now try and illustrate these principles by a few examples, and point out to you some of the protean forms in which this asphyxial element appears in actual practice. There is no difficulty in recognising it when it appears in its native hideousness, as was the case in the old method of gas administration. Here oxygen was excluded till the patient had passed well into the second stage of asphyxia; then the operation was begun, and by the time the asphyxia had passed off the patient had regained consciousness. Experiments have shown that after breathing nitrous oxide for a period of 105 seconds, the oxygen in the blood is reduced from 21 to 5.2 vols. per cent.; in other words, more than three-quarters of the oxygen in the blood had been used up by the tissues, and since oxygen is essential to the life, not only of the organism as a whole, but to each cell in that organism, you see how near death a patient may be brought by this method of the administration of gas. If then, after such an administration, the respiration ceased from any cause, there is but a small margin of time during which it is possible to restore the patient. Fortunately, in the vast majority of cases this margin, though small, is sufficient, and by artificial respiration it is possible to introduce a fresh supply of oxygen. In such cases the signs are so evident and so aggressive that there is no possibility of mistaking them, and no difficulty in recognising what treatment is necessary.

The success of this treatment, however, depends on the fact that usually the action of the heart continues in spite of the cessation of the respiration, for not only must the oxygen get to the blood, but also the oxygenated blood must get to the tissues, and especially to those tissues the integrity of which is essential to life, that is the great nerve centres of the medulla. One of the conditions of asphyxia, however, we have seen is that the right side of the heart becomes distended with blood, while the left side becomes empty. The empty ventricle, however, cannot contract, and in the distended ventricle the force which is necessary to expel the blood increases as the cube of the radius of the cavity, so that the work thrown on the heart is greatly increased. If the heart is healthy it may be able to meet this extra strain, but if it be debilitated or degenerated it may be quite unable to do so, with the result that death takes place.

In the earlier stages of asphyxia we have seen that there is a very considerable rise in blood pressure. This means more work for the heart and considerable strain on the walls of the arteries. If the arteries are degenerated, as is so commonly the case in old people, they may rupture, and possibly a fatal cerebral hemorrhage result, as has actually been recorded in practice, and hence old age has been given as a contraindication for gas anaesthesia. The only remedy here, it is needless to say, is prevention.

These are extreme conditions, and, fortunately, not commonly met with in practice; there are, however, others, not so dangerous perhaps, but sufficiently objectionable to justify considerable trouble to avoid them. As such may be mentioned the jactitation so commonly met with in gas anaesthesia, and which is so inconvenient to the operator. This is really the clonic convulsions of the second stage of asphyxia, and may easily be abolished by the simple expedient of allowing the patient more air. There is another phenomenon perhaps more annoying, but which is not so well recognised as due to the want of oxygen. I refer to the struggling often met with in the earlier stages of the administration before the patient is "off." You are all familiar, by reputation at all events, with the struggles of the drowning man, that is the violent conscious efforts which are stimulated by the feeling of smothering or want of oxygen, the feeling that one must get air at any cost. I am convinced that the cause is the same in the two cases—the want of oxygen. This struggling is not so commonly met with during the administration of nitrous oxide as it is during that of ether, for the simple reason that, in the case of the former, consciousness is usually abolished before the want is felt, while in the latter it is not. In proof of this I have found that in the case of men who often require a considerable quantity of gas to anaesthetise them struggling is likely to take place. Hence the old teaching was that the way to subdue these struggles was to press the anaesthetic, whereas the truth is they can be much more quickly, effectually, and pleasantly abolished by the admission of some air. This I have found to be true after some bitter experience in my own practice, and now always endeavour to anticipate their onset either by a rapid anaesthetisation with gas or by the free administration of air with the anaesthetic.

In many cases the only evidence of asphyxia which will be present is the great increase in the frequency and depth of the respirations—that is, the hyperpnoea of the first stage. It is, however, very important to recognise this, not only as a warning of what will certainly follow if it is neglected, but also because often this overstimulation of the respiratory centre is apt to be followed by a period of apnoea or absence of respiration, which before it passes off may induce a very profound degree of asphyxia causing considerable trouble and alarm. I have seen patients in this condition become almost black in the face to the great alarm of the bystanders before respiration was again re-established. Under ordinary circumstances the condition is devoid of danger, but in the case of a weak heart or degenerated vessels it might possibly lead to a fatal result, besides, in my experience, it is almost always followed by very violent headache after recovery.

Many of you will have found when beginning extractions under anaesthetics that the swollen state of the tongue considerably impedes your manipulations in the mouth. This condition results from the fact that in the conscious state the muscles of which the tongue is composed are in a state of tonic contraction, while during anaesthesia they are more or less relaxed. Now asphyxia, even in slight degrees, leads to the stagnation of the blood in the veins, and thus in the tongue the swelling due to the relaxation of the muscles may be greatly increased so much so that any operation in the mouth is rendered very difficult. This venous congestion also favours hæmorrhage from the sockets of the extracted teeth which further obstructs the operator. This is a matter of no little importance when the time available for operation can only be counted in seconds.

I have said perhaps enough to convince you of the advisability of avoiding the asphyxial element in anaesthesia, and these remarks apply with as much force to the administration of ether as that of gas, while in the administration of chloroform any asphyxia is attended with great and special risks. In the case of nitrous oxide anaesthesia it is not always possible to avoid it altogether, and often it may be advantageously made use of as a help, but this should only be done knowingly, and in so far as it is possible to keep it properly under control. In many cases it is not easy to get a sufficient depth of anaesthesia without it, that is, to administer enough gas to anaesthetise the patient while at the same time we give enough air to supply his oxygen needs. This was the reason why the introduction of nitrous oxide and oxygen anaesthesia was such an improvement on that of the pure nitrous oxide. You will remember that the atmospheric air contains some 79 per cent. of nitrogen, which for respiratory purposes is absolutely useless, so that to give 21 vols. of oxygen one must give 100 vols. of air. It is not at all an easy matter to give this large quantity of air and still give enough gas to maintain anaesthesia, so that a slight limitation of the oxygen may not only be useful but necessary, this should only be done, however, with a full knowledge of its effects, and the limitation should never be permitted to go on till the dangerous symptoms of asphyxia arise.

As regards treatment the indications are plain and unmistakable. Supply oxygen either by permitting the patient to freely breathe air, or by compelling him to do so by means of artificial respiration if the natural function is in abeyance. In order to accomplish this it is necessary to see that the air way is free and unobstructed, either by the tongue falling back, or by blood or other foreign body in the air passages. As long as the circulation is maintained, and the air way clear, one or two respirations are sufficient to lessen the cyanosis and indicate the onset of recovery. If this does not at once take place you may conclude that either the air is not entering the lungs or that the heart is not driving the oxygenated blood into the peripheral arteries. Thus, if the pulse continues to beat you are justified in the conclusion that the air is not passing into the lungs, and that either there is some obstruction in the air passages, or your method of artificial respiration is inefficient. In the former tracheotomy should be performed at once unless the obstruction can be removed, as any delay is attended with the very greatest risk. If it is the circulation that is at fault tracheotomy is useless, or worse than useless, being absolutely harmful as adding a further and unnecessary shock to the patient. The condition will in this case be the result of one or two causes: either syncope from the want of a sufficient supply of blood in the heart and great vessels, or obstruction of the heart from over-distension. It is of great importance to diagnose which of these conditions is present, as the treatment of each is diametrically opposed. This diagnosis in many cases is by no means easy, but with due care and attention can generally be made. If the condition has arisen early in the administration after struggling, and is attended with marked congestion of the face and deep cyanosis the probability is that the case is one of over-distension, while if it occurs later after the administration has continued for some time, and then comes on suddenly without warning, being attended with pallor

rather than cyanosis it is most likely due to syncope. In the latter case complete inversion of the patient is the best remedy, while if there is over-distension of the heart this procedure will only aggravate the condition. In cases of over-distension one should endeavour to empty the heart by intermittent pressure over the pre-cordial area, and possibly also open one of the jugular veins, artificial respiration being kept up continuously in each case. Drugs here are probably quite useless, for if the circulation have stopped it is impossible to convey them to the organ on which it is wished that they should act. Electrical stimulation is also useless, for if it reaches the heart at all, which is doubtful, it would probably inhibit its action. From this you will see that the curative agents at our disposal are not very numerous, nor are they very efficacious, hence there is all the more reason for avoiding the necessity of using them by proper preventive treatment.

If by these remarks I have been able to stimulate your interest in this subject, and force on your recognition a sense of the responsibility which one undertakes who administers a general anæsthetic I shall have the satisfaction of feeling that I have done a good evening's work. Let me warn you, however, that it is only by actual practice that one can become a good anæsthetist, and practice, too, with unremitting care and watchfulness of the cases that come under one's charge. No case is so simple that complications may not arise, no case so ordinary that something may not be learned from it by careful study.

**THE VALUE OF  
AGE AND SEX AS ÆTIOLOGICAL FACTORS  
IN THE  
DIFFERENTIAL DIAGNOSIS  
OF  
GASTRIC ULCER AND CARCINOMA.**

By WILLIAM MURRELL, M.D., F.R.C.P.,

Physician to the Westminster Hospital; Lecturer on Clinical Medicine; Joint Lecturer on the Principles and Practice of Medicine and Examiner in the University of Glasgow.

THE diagnosis between ulcer and cancer of the stomach as a rule presents no difficulty, but age and sex are factors of some importance. It is often said that gastric ulcer is a disease of young women and follows in the wake of anæmia, whilst gastric carcinoma affects chiefly middle-aged men. Let us see to what extent this opinion is confirmed by statistics.

I. *The Relative Frequency of Gastric Ulcer in Men and Women.*—I have examined the reports of the Westminster Hospital from 1884 to 1900, a period of 17 years, and find that of 397 cases of gastric ulcer seen in the wards 69 were in men, and 328 in women. This gives a ratio of 1 to 1.475.

Welch, as the result of 1,699 cases of gastric ulcer met with at autopsy, found that 40 per cent. were in men, and 60 per cent. in women, which works out 680 cases as against 1,019.

Fenwick, at St. Mary's Hospital, out of 383 cases, found 95 in men, and 288 in women.

Lebert, of 209 cases diagnosed during life, found 47 in men, and 162 in women.

Habershon, out of 201 cases found 74 in men, and 127 in women.

Martin, from the records of 171 cases at University College Hospital, gives 27 cases in men, and 144 in women.

Anderson, of 35 cases, found 3 in men and 32 in women, whilst Steiner, of 19 cases, found 8 in men, and 11 in women.

Tabulating these results, we get the following figures:—

	No. of Cases.	Men.	Women.
Welch ...	1,699	680	1,019
Murrell ...	397	69	327
Fenwick ...	383	95	288
Lebert...	209	47	162
Habershon ...	201	74	127
Martin ...	171	27	144
Anderson ...	35	3	32
Steiner ...	19	8	11
	3,114	1,003	2,111

This gives a ratio of 1 man to 2.10 women, but, excluding Welch's autopsies, we get 1,415 cases with 323 men and 1,092 women, which gives a ratio of 1 to 3.38.

II. *The Ages at which Gastric Ulcer occurs.*—The following is the result of the analysis of the 397 Westminster Hospital cases:—

Under	5 years	...	...	0
	5-10	"	"	2
	10-20	"	"	62
	20-30	"	"	182
	30-40	"	"	104
	40-50	"	"	32
	50-60	"	"	10
Over	60	"	"	5
			Total	397

Welch gives the following table of 607 cases collected from hospital statistics:—

1-10 years	...	1
10-20 "	...	32
20-30 "	...	119
30-40 "	...	107
40-50 "	...	114
50-60 "	...	108
60-70 "	...	84
70-80 "	...	35
80-90 "	...	6
90-100 "	...	0
Over 100 "	...	1
		Total 607

Martin in his table distinguishes between males and females, but by adding the cases together we get the following figures:—

Under 20 years	...	15
20-30 "	...	75
30-40 "	...	38
40-50 "	...	25
50-60 "	...	14
Over 60 "	...	4
		Total ... 171

Fenwick differentiates between acute and chronic ulcers, and takes as his standard the age at death, but by grouping his cases we arrive at the following results:—

10-20 years	...	9
20-30 "	...	17
30-40 "	...	16
40-50 "	...	28
50-60 "	...	12
60-70 "	...	6
70-80 "	...	1
		Total ... 89

His conclusion is that whereas acute ulceration is almost confined to young women, the chronic form is much more common in men.

By combining these results we get the following totals:—

	Under 20	20-30	30-40	40-50	50-60	Over 60	
Welch ...	33	119	107	114	108	126	= 607
Murrell ...	64	182	104	32	10	5	= 397
Martin ...	15	75	38	25	14	4	= 171
Fenwick	9	17	16	28	12	7	= 89

121 893 265 191 144 142 = 1,264

This gives the preponderance of cases in the

decade 20-30, which is in accordance with the view commonly entertained.

III. *The Relative Frequency of Gastric Cancer in Men and Women.*—Let us now apply the same mode of investigation to gastric carcinoma. At the Westminster Hospital in the seventeen years—1884-1900—there were 92 cases in the wards, and of these 60 were in men and 32 in women, a ratio of 2 to 1.

Reiche reports the statistics at Hamburg (1872-1898), and finds that of 4,237 deaths from cancer of the stomach 2,387 were in males and 1,850 in females.

Welch, of 2,214 cases collected from hospital statistics, and nearly all confirmed by autopsy, gives 1,233 males and 981 females. He adds that if to these accurate statistics be added collections of cases from heterogeneous sources, including mortuary returns, there results a total of 5,426 cases, with 2,843 males and 2,583 females. In this record is not included any of the other cases here mentioned.

Osler and McCrae, out of 150 cases, give 126 in males and 24 in females, a proportion of 5 to 1.

Martin found in 53 cases 32 in men and 21 in women.

Combining the numbers we get:—

	No. of Cases.	Men.	Women.
Welch ... ..	5,426	2,843	2,583
Reiche ... ..	4,237	2,387	1,850
Osler and McCrae ...	150	126	24
Murrell ... ..	92	60	32
Martin ... ..	53	32	21
	9,958	5,448	4,510

This gives a ratio of 1.20 to 1, or 6 to 5. Brinton thought that gastric cancer was twice as common in men as in women, but Welch, with his much larger statistics places the ratio at about 5 to 4, and considers that the difference is so slight that no importance can be attached to it, especially as in many hospitals the men are in excess of the women.

IV. *The Age at which Gastric Carcinoma Occurs.*—Taking the ninety-two Westminster Hospital cases, I find that there was no patient under the age of 30. In the decade 30-40 there were 11 cases; 40-50, 33 cases; 50-60, 25 cases; and over 60, 23 cases.

Brinton collected 600 cases from various sources, but does not tabulate the results. He states, however, that the average age at death was 50, and that the maximum number of cases, 162, or 2.7th, occurred between 50 and 60. Both Welch and Reiche have published series of cases, which are tabulated below:—

	Welch.	Reiche.	
10-20 years ...	2	0 =	2
20-30 " ...	55	6 =	61
30-40 " ...	271	17 =	288
40-50 " ...	499	38 =	537
50-60 " ...	620	49 =	669
Murrell Two			
60-70 " ...	428	36 =	464
70-80 " ...	140	4 =	144
80-90 " ...	20	— =	20
Over 90 " ...	3	— =	30
	2,038	150 =	2,188

From this it will be seen the majority of cases occur between the ages of 50 and 60.

The conclusions at which we arrive are that gastric ulcer is from two to three times as common in women as it is in men, and that it is most frequent between the ages of 20 and 30. On the other hand, gastric cancer is slightly more common in men, and the majority of cases occur over the age of 50.

It is stated that the Secretary of State for India has sanctioned an increase of twenty-six officers to the Indian Medical Service in order to mitigate the difficulty in respect of obtaining leave.

## THE TREATMENT OF INOPERABLE CANCER. (a)

By ALFRED COOPER, F.R.C.S.,

President of the West London Medico-Chirurgical Society.

GENTLEMEN,—The honour which you have done me by electing me as your President is one of the greatest which I have yet received, for, although the West London Medico-Chirurgical Society is young in years, it is, I believe, by far the most active in work and growth of all the medical societies in London.

On taking the chair for the first time, I follow the example of my predecessors by giving a short address on some subject which will be of interest to all the members, and I have thought that I cannot do better than draw your attention to a consideration of the present treatment of inoperable cancer, a disease which has attacked the highest in the land, and which is certainly becoming more prevalent.

It is in the cases of so-called inoperable cancer that it is not only justifiable, but wise to try remedies other than operation. During the last decade attention has been drawn to a number of methods of treatment, and I will briefly give you the information which I have been able to collect on the subject, and shall refer to the following methods:—

1. The inoculation with the streptococcus of erysipelas; 2, subcutaneous injections of Coley's fluid; 3, subcutaneous injection of anticancerous serum; 4, oöphorectomy; 5, thyroid feeding; 6, lymph gland feeding; 7, by Röntgen rays, and by Finsen's light treatment; 8, by the injection of various irritating substances and the production of aseptic supuration; 9, by electricity; 10, by drugs.

*The Cure of Malignant Diseases by Erysipelas.*—Nearly 200 years ago it was observed that a certain number of malignant growths disappeared after an attack of erysipelas, and attention has particularly been drawn to the subject by Fehliesen and Biloeth who have reported cases of inoperable sarcoma cured by an attack of erysipelas. Quite recently Eschmeiler, of Bonn, collected a series of fifty-nine cases of malignant disease associated with erysipelas, occurring either spontaneously or produced by inoculation. Of these fifteen, or 25 per cent., recovered, while six of the others died of erysipelas. After the discovery of the streptococcus Fehliesen suggested that an inoculation of a cultivation of the organism might be used to produce a like result; he obtained a cure in a case of cancer of the breast, and in four other cases there was temporary atrophy of the tumour. In other hands, however, several fatal cases occurred. The next advance was made by Lassar, of Berlin, who injected the toxin of erysipelas alone, after sterilising the culture by steam. This fluid was found to be too weak. Finally Coley, of New York, introduced the use of the mixed toxins of the streptococcus of erysipelas and the bacillus prodigiosus, a preparation based on the discovery of Professor Roger, of Paris, who found that the addition of bacillus prodigiosus greatly enhanced the virulence of certain pathogenic organisms, and among these organisms was the streptococcus of erysipelas. Coley has used this fluid in 148 cases and out of these twenty-four, or 15 per cent., improved. Six of these cases afterwards recurred, but the remaining 12 per cent. were permanent successes, some of the cases having remained well for six years. It is found that the greatest chance of improvement is in spindle celled or mixed-celled sarcoma. Coley considers the results in carcinoma as unsatisfactory.

(a) Abstract of an Address delivered before the West London Medico-Chirurgical Society, on October 4th, at the Opening of the Session, 1901-1902.

*Treatment by Anticancerous Serum.*—Last year Vlaieff introduced in Paris a method of treatment of advanced malignant diseases by inoculation with a special anticancerous serum. In two cases of epithelioma of the tongue an improvement followed. In a more recent paper Vlaieff states that he has treated sixty cases of human carcinoma by this method. When it was administered early, before ulceration and glandular enlargement, the serum was capable of exercising a curative effect.

*Oöphorectomy.*—Much of our knowledge on this subject we owe to Mr. Stanley Boyd, from whose paper in the *Brit. Med. Journ.* I have freely drawn in the following remarks.

According to Mr. Boyd, Dr. Beatson, of Glasgow, was led to consider that oöphorectomy would be useful in treatment of inoperable cancer of the breast by the following considerations: "In lactation there is rapid multiplication of mammary epithelium. Beatson learnt that certain farmers spayed lactatory cows in order to maintain permanently or for a long time the secretion of milk. In cancer also the mammary epithelium multiplies rapidly, but instead of undergoing fatty degeneration or being cast off, it distends the acini, penetrates into the lymph spaces of the breast, and there floating in a nutrient fluid, continues multiplying and forcing its way onwards towards the lymphatic glands. As oöphorectomy in the cow maintains fatty degeneration of the epithelium of the lactatory breast, Beatson thought it might induce fatty degeneration of the epithelium of the cancerous breast. Mr. Boyd last year collected fifty-four cases of oöphorectomy for cancer, which were in no way selected cases, but included the whole experience of several surgeons. As a conclusion, he considers that life was prolonged an average of six months by the operation. Out of the fifty-four cases nineteen or 35 per cent., were more or less markedly benefited by the operation, and only one died. Although one-third of the cases derived benefit from the operation, in the majority of these the cancer began to reappear or to increase within from six to twelve months. A curious part is that the average age of the cases improved by operation was higher than that of those who were unaffected, and therefore the operation seems most favourable when performed near to the time of the menopause; it is also found that chronic cases are more likely to be benefited than acute ones, but the quantity of superficial disease does not appear to have any influence. As the practical results of his investigation, Mr. Boyd thinks that oöphorectomy should be offered in all cases, other than the very acute, of inoperable mammary cancer in women over forty with no visceral or bony lesions, and before the menopause.

*Thyroid Feeding.*—This method is also due to Dr. Beatson, of Glasgow, who considers that the so-called cancer bodies are not parasites, but are cells undergoing mucoid degeneration, and he therefore thought that a free administration of thyroid extract might influence them greatly, and in time effect a cure. Dr. Bell, of Glasgow, was favourably impressed with the use of thyroid feeding, and tried it in two cases of epithelioma of the cervix, and states that he obtained satisfactory results. Butlin, on the other hand, tried it in a good many cases, but has not obtained even temporary benefit in a single case.

*Lymph Gland Extract.*—Somewhat analogous to thyroid feeding is the treatment by means of lymph-gland extract, recommended by Dr. Snow. Snow states that he has used that treatment in several cases of mammary cancer which resulted in considerable improvement.

*Treatment by "X" Rays.*—Several cases of rodent ulcer have been treated in the West London Hospital by means of exposure to the "X" rays. The ulcer

is usually treated after about a month or six weeks; the treatment, however, should be continued until all induration has disappeared. Sequeira has tried the treatment in twelve cases. Out of the twelve cases four are under observation, the ulcers having healed, while eight are still under treatment. Dr. Abraham, our dermatologist, has treated two cases, and both have been cured. Mr. Andrew Clark has recorded a case of chronic cancer of the breast treated for two months by the "X" rays with beneficial results. The action of the Böntgen rays is almost similar to that of Finsen's light treatment, and several cases of rodent ulcer have been treated by that method; the treatment, however, is more painful than that by the "X" rays, and does not possess any advantages. Too few cases have been treated by either method to form any definite conclusion.

*Irritating Injections.*—Among these are: 1, the parenchymatous injection of acetic acid; 2, the parenchymatous injection of alcohol; 3, the parenchymatous injection of methyl violet; 4, the parenchymatous injection of cobra capella venom; 5, artificially produced suppuration by (a) oil of turpentine, (b) arsenious acid, (c) calcium carbide.

1. *Treatment by Parenchymatous Injection of Acetic Acid.*—More than thirty years ago, in 1866, my attention was drawn to this method by Sir William, then Dr., Broadbent. It was interesting to note that, though the injection of acetic acid is extremely painful in healthy tissues, when injected into a carcinoma it gives little or no pain, and that while it produces no effect on normal structures, it acts energetically on cancer, producing solution of portions of the tumour. Broadbent employed about eighty minims of a mixture of the strong acetic acid of the B.P. with three or four parts of water. It was not claimed for this method that it was curative, but that it prolonged life, and rendered the patient's sufferings less severe. Remembering the success that Sir William Broadbent had obtained, I wrote to ask him if he could give me any further results. I think that his reply will interest you. He says:—"I had a great many cases afterwards, and had to give it up, not because it was a failure, but because I did not want to get a reputation as a cancer doctor. I gave my syringe to a surgical colleague, but he preferred the knife. The injection always relieved pain. The strength of the acid I eventually came to use was, I think, one in seven."

2. *Parenchymatous Injection of Alcohol.*—This was first advocated by Schwalbe and Hesse in 1872. A 30 per cent. solution of alcohol was used at first, the strength being gradually increased to 40 or 50 per cent. Although it has been used a considerable number of times in this country, it has apparently not been very successful.

3. *Parenchymatous Injection of Methyl Violet.*—Von Maestig Moorhof introduced this method; 1 in 50 watery solution was used. This treatment has been tried in the West London Hospital without producing any benefit. I have been unable to find any evidence of a cure following the treatment.

4. *Parenchymatous Injection of Cobra Capella Venom.*—The dry venom was employed by Répin in doses of a 40th of a milligramme, injected hypodermically. The remedy was found to be both painful and dangerous.

5. *Artificially Produced Suppuration.*—(a) By oil of turpentine. Czynski treated some cases of advanced carcinoma by this method, but the advance of the disease was in no way checked. (b) By arsenious acid. Winth produced profuse suppuration in a sarcoma of the abdominal wall by this method, and the tumour disappeared. Ten years later there had been no recurrence.

(c) By carbide of calcium. Etheridge, of Chicago, treated carcinoma of the uterus with this substance

which in the presence of water produces acetylene gas. In two cases a cure was obtained.

**Electricity.**—Dr. Parsons has treated several cases by means of currents having a high electro-motive force. Although some of Dr. Parsons' cases improved, one patient at least died from the shock of the use of too strong a current. Massey employed a zinc electrode heavily coated with mercury, the negative pole being connected with another part of the body. Eight cases were treated, and improvement was seen in all. I should like to mention that two gentlemen are at present experimenting on several cases of cancer with electric currents of very high voltage. The treatment is absolutely painless, and the results show marked diminution in the size of the tumour and great improvement in the general health. The cases have only been under treatment a short time, but we may find in it an important addition to our treatment.

**Treatment by Drugs.**—*Cheledonium Magos* (Celandine).—Spirak has collected sixty-one cases treated by fourteen different surgeons in this way; of these thirty-three showed improvement and twenty-seven did not.

Mention should be made, too, of the great benefit following the exhibition of large or increasing doses of *morphia* in hopeless cases.

As a result of this review of the different remedies which have been recommended to me, I think, arrive at the following conclusions:—

1. That in cases of inoperable sarcoma, more especially the spindle-celled variety, the patient should have the option of Coley's fluid given to him.

2. In cases of inoperable cancer of the breast in women of about forty years of age, in whom the menopause has not occurred, the operation of oophorectomy should be proposed, and this treatment may be combined with thyroid feeding.

3. In cases of inoperable rodent ulcer, and in the superficial malignant ulceration in other parts, the Röntgen rays give a good hope of improvement.

4. In cases where these other methods are declined or are inapplicable, the internal administration of celandine is worthy of trial, and when the case appears quite hopeless *morphia* should be pushed without hesitation.

5. The parenchymatous injections of acetic acid are also worthy of trial.

In conclusion, I should like to express my thanks to my friend, Mr. L. A. Bidwell, for the able assistance he has given me in investigating the subject.

### Clinical Records.

#### INTESTINAL OBSTRUCTION CAUSED BY UNSUSPECTED UTERINE FIBROMYOMA, SIMULATING APPENDICITIS. (a).

By WILLIAM TRAVERS, M.D. Durh., F.R.C.S. Eng.

I WAS summoned, a few months since, late at night, to see a lady's-maid suffering from very acute abdominal pain—this was the fourth day of the attack. She was a martyr to constipation, and despite strong aperients and enemata, had had previously several severe attacks of "obstruction," in one of which, two years since, a fatal consequence was feared; the pain and tenderness accompanying them was always in the right side. I found a tall, slightly built woman, *æt.* 40, with an anxious flushed face expressive of much pain, decubitus dorsal with flexed knees, respiration quick and shallow, pulse 100, temperature 100°. She had been once sick. The abdomen was slightly tympanitic, scarcely moving in respiration, and not at all over right iliac quadrant, dreading to be touched, and very tender all over, especially in this region. There was a

general resonance, but wooden over the same part, where, too, although pain prevented at all careful palpation, there was distinct feeling of resistance and as if there must be some solid matter beneath. The affected part was bounded superiorly by a distinct rounded line. The attack had begun with more than usual constipation and pain: severe treatment with drugs had produced two free evacuations on this last day, with exacerbation of all the symptoms. The lower bowel was empty and ballooned; on the right side high up some fulness could be felt. On very careful inquiry I could ascertain no history of any past or present uterine fault, and as she was now menstruating no vaginal examination was made. The symptoms pointed to appendicial trouble, and her condition was sufficiently severe to call for surgical interference. At this late hour of the night, now 11.30 p.m., and under the novelty of the circumstance to those about her—all her friends, too, living a long way off—I felt justified in leaving her for the night, giving opium gr.  $\frac{1}{2}$ , codeia gr.  $\frac{1}{2}$ , ex. belladoni gr.  $\frac{1}{2}$  at once, the dose to be repeated each fourth hour. The abdomen was carefully swathed in cotton wool.

I saw her again at 8 a.m., although her symptoms were not more urgent no one had abated. The pulse and temperature were the same as on the previous night. The acute pain had been relieved by the pills and she had had some very broken sleep; however, she looked certainly worse, even to her mistress's eyes. She had been sick once again only, and there was more distension, no flatulence had passed. I urged an operation at once, emphatically, but under the circumstances suggested that she should have the benefit of another opinion and wished that Dr. Schacht should see her with me; this was cordially agreed to, and he met me half an hour later. His views coincided with mine as to the course to be pursued and as to the probable cause of the condition. We proceeded to operate, my friend Mr. Barton kindly giving the anæsthetic. A four inch curvilinear incision outside the right rectus muscle and ending about the middle of Poupart's ligament, was made down to the peritoneum; this latter membrane was injected and thickened; on incising it the subperitoneal tissue was found very adherent to the bowel underneath by recent and earlier adhesions, carefully separating these with the fingers a large mass of scirrhous-like hardness, was felt closely attached to the bowel, to its outer side, and adherent to the pelvic wall; by carefully tearing through the adhesions this growth was with some difficulty brought through the wound, now increased in length for the purpose, when it was found to be closely bound to, but not incorporated with, the colon wall; the ascending colon and cæcum were very injected and dilated, but otherwise healthy. There was a good deal of free oozing—the mass, evidently fibroid, was carefully cleared from its surroundings, a kind of pedicle formed, tied, and the tumour removed. The wound was carefully closed and the patient placed in bed. She gave me no anxiety throughout her convalescence; she gained strength slowly, and we had some trouble at first with the action at the bowels, but at no time was there the difficulty she had found previously.

I have seen her on several occasions since; she is performing all the duties of her office without discomfort, and her constipation is easily negotiated with. At the time I saw her it was impossible to palpate sufficiently carefully to discover the growth even of this size (tumour shown) and none of her earlier symptoms led me to expect such a cause for her severe attack. She had no nervous suspicion that any abdominal tumour existed.

On after examination the fibroid was found to have no real pedicle. The one ligatured consisted only of a rope of thickened cellular tissue containing blood-vessels.

THE KING, who was recently graciously pleased to become patron of the new Dental Hospital of London, Leicester Square, has now commanded that in future the Institution shall be known as the Royal Dental Hospital of London.

(a) Read before the British Gynecological Society, Oct. 10th, 1901.

## Department of Lunacy.

### TWELFTH ANNUAL REPORT OF THE ASYLUMS' COMMITTEE OF THE LONDON COUNTY COUNCIL.

THIS report is now to hand, and deals with various matters of interest in lunacy affairs for year ended March 31st. There is first of all discussed that perennial topic of interest the increase of lunacy. Deductions are drawn from returns by the clerks to the guardians. These returns comprise information regarding all classes for the mentally affected, of whatsoever degree and social position, and it is gratifying to know that this is the first time that an actual reduction in the total number of pauper lunatics has been recorded by the Committee, though it does not always follow that this is due to a real reduction, but to alteration of statistical areas. While it cannot be said that there is any appreciable reduction going on, there appears to be a diminution in the rate of increase during the last few years, which, of itself, is very satisfactory.

A plan of an epileptic colony appears in this report. The Committee has entered very fully into this new question, and provision has been made for a working colony of 300 male epileptics at a cost of about £90,000.

The general review of the year is short in its paragraphs, and the incidents there recorded present nothing specially new. Evidence, however, is still abundant of a high degree of efficiency and much thoroughness in the administration.

The several reports of the various superintendents are, as usual, full and interesting, and to most readers, and, especially to those who are not associated with asylum work, the report of Dr. Mott, the pathologist, will be found, as usual, most interesting. He seems to have attracted more and more disciples to his laboratory, and we notice that several have come from America. He is still working with a good deal of competent assistance at such subjects as syphilis, general paralysis, epilepsy, idiocy, and the pathology of herpes zoster, and pursuing his interest in colitis or asylum dysentery. Dr. Mott has long wished to find some one competent to undertake an experimental psychological inquiry of mental diseases, and he reports "that W. G. Smith, M.A. Edin., Ph.D. Leipzig, who has worked for upwards of two years in Germany in the psychological laboratories of Professor Wundt and Professor Munsterberg, and studied mental diseases under Professor Flechsig, has undertaken charge of this department. The papers which he has already published deal chiefly with the subjects of memory, association of ideas, and reaction to stimuli. He wishes now to carry on the study of psychological phenomena in their pathological relations, a line of investigation which is being promoted in an increasing degree in institutions for the treatment of the insane in Germany. The problems which he proposes to study in the laboratory are (1) the pathological changes in mental states, such as memory and association of ideas, particularly in individuals suffering from alcoholic dementia; (2) the phenomenon of reaction time in normal and abnormal individuals, as studied both by the measurement of the duration of mental processes and by analysis of the motor phenomena by the graphic method. A short preliminary paper upon one of these subjects will appear in the Archives."

### FORTY-THIRD ANNUAL REPORT OF THE GENERAL BOARD OF COMMISSIONERS IN LUNACY FOR SCOTLAND.

FRAMED, as usual, this report is on interesting lines, the whole scheme of description of the movement of lunacy administration is very interesting. It is less dry and statistical than the English report, and more practical in its evident purpose. The statements made in the appendix "B" regarding different asylums are useful and interesting. In the case of the Argyll Asylum we notice a remark by the Commissioners expressing regret that there is a disinclination on the part of many of the parish councils in the district to

board out their patients. The Commissioners regard this as unfortunate both in the interests of the rate-payers and many of the patients. We are glad to see this, because we feared of late years that the scare occasioned by an unfortunate occurrence in a boarding-out district had too much damped the enthusiasm of the Commissioners in the matter. There is always considerable industrial activity in this asylum, and the medical administration seems very good.

The Commissioners have during the past few years given special attention to the subject of asylum dietaries. They have made a most active and intelligent move in the matter, and have obtained by Government sanction the employment of Dr. Craufurd Dunlop, of Edinburgh, to assist them in preparing a report on the dietary of pauper lunatics in Scottish lunatic asylums.

It is gratifying to observe that the Commissioners have taken an interest in the pathological work of the Scottish Asylums' Laboratory. Here, as in other individual efforts of our Scotch asylum men, they have given the full benefit of their moral and intellectual support, and, without doubt, will help to the best of their ability in this new movement.

## Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, October 19th, 1901.

### TREATMENT OF PROLAPSUS UTERI BY A SIMPLE OPERATION.

PROFESSOR DURHESEN (*D. Med. Zeit.*, 74, 1901) recommends a simple operation for the treatment of the above-named distressing complaint. After amputation of the cervix, if called for, the anterior vaginal vault is incised transversely, and the writer adds to this a longitudinal incision. The vaginal part is separated from the bladder either by tearing or cutting, when the bladder presents itself connected to the cervix and the parametrium by a layer of fascia. The central part of this may often be severed by a blunt instrument. Its remaining lateral portions, which are tense, are then ligatured and cut through. The bladder may now be pushed away from the parametrium, both at the sides and centrally, and when pushed upwards and the whole body of the uterus pulled down by forceps the bladder wall comes well into view. If no further pregnancies are expected the fundus is drawn down and fixed into the vagina by three catgut sutures. The vaginal flaps are then replaced, the fixation sutures tied, and the wound drained by gauze.

The same journal contains an account of a

### FATAL RUPTURE OF TUBAL PREGNANCY AT THE SIXTH WEEK,

reported by Dr. Strauch. The fatal result is believed to have been due to an error in diagnosis on the part of the practitioner who saw the case first. The patient, a young woman, *æt.* 23, had been married six months, and her last period had come on six weeks before the onset of the illness. At this date, in the evening, after partaking of fish at supper, she fainted whilst at stool, and this was followed by violent vomiting. The medical man who was called in found her pulseless, and attributed the illness to poisoning by the eating of the fish for supper. The reporter first saw the patient at four o'clock the next day; diagnosed ectopic gestation, and proceeded to operate at once. A large quantity of blood was found in the abdominal cavity, which appeared to have escaped from the ruptured tube. The operation was easily performed, and only took up ten minutes, but the patient died half an hour afterwards. He was



of opinion that the life could have been saved if the operation could have been performed sufficiently early after the accident. The teaching of the Lyons School to the effect that ruptured tubal gestation is not fatal before the fourth month is erroneous, as proved by the case recorded.

The *D. Med. Woch.*, 20/1901, has an article on

#### CONCEALED GASTRIC HÆMORRHAGE,

by Dr. J. Boas. Hæmorrhages from the mucous surfaces of the stomach occur in two forms:—first, as copious hæmorrhages; secondly, as small hæmorrhages proceeding from capillaries, or ulcers, or ulcerating tumours. In either case the blood may retain its normal colour, or be of the well-known coffee-ground shade. If the hæmorrhage is slight there may be no discernible change in the appearance of the contents of the stomach if these be acid. The writer's attention was drawn accidentally to the occurrence of such occult hæmorrhages, and since then he has observed it in eighty-three cases of the most varied disturbances of the stomach and intestines on examining the contents of the stomach. A survey of the material collected shows three groups of cases: first, diseased conditions in which hæmorrhages are never present; then diseases in which hæmorrhage is occasionally present; and, thirdly, cases in which hæmorrhages are constantly or repeatedly found on examination. The first group comprises all the neuroses, all the cases of gastritis anacida, a case of gastritis subacida, cases of hyperacidity, hypersecretion, and benign ectasy. The cases of occasional hæmorrhage comprise those of gastric ulcer and stenosis of the pylorus. Among them blood was found repeatedly in four cases, but not constantly. To the three groups belong first a case of gastritis with stenosis and all cases of carcinoma of the stomach. In these latter, independently of the character of the chemical and motor functions blood was always found in the gastric contents, mostly in pronounced quantities by the guaiacum test. In certain of the cases the appearance was more or less suspicious, but in most of them even on careful inspection there was no reason to believe that blood was present. In the cases where blood could be suspected from the appearance alone, it was often found in the stools also, even when there was no noticeable change in their colour.

#### WHY DOES CEREBRAL SYPHILIS APPEAR DIFFICULT OF CURE?

is the title of an article by Dr. O. Ziemssen in the *Berl. Klin. Woch.*, 18/1901.

The first reason given by the writer is the fear of many physicians that the quantity of mercury required has a tendency to cause neurotic diseases. Another reason is the difficulty of diagnosis in the early stages. A further reason lies in the course of recovery itself. Possibly there is an idea that brain disease, the same as spinal disease, does not depend on syphilis when after three or four weeks' treatment results do not show themselves and no apparent retrogression takes place. This idea is erroneous, as the appearances may really depend on the natural course of recovery. In fact, in recovery from brain syphilis an interesting insight is afforded into the complicated relationships within the brain. It is undoubted that every second of waking life must leave a lasting impression on the brain. A simple calculation shows that the brain of a man of thirty or forty receives a milliard different impressions

and must bear traces which may recall any given moment even after many years. The recovery from brain disease often brings back these traces in most variegated series. Whilst in other syphilitic diseases the dark changes of the eyes or the sense of touch are noticeable, when the brain is the seat of the disease they are shown in incoherence of thoughts, in loss of memory, and sometimes even in opposition to the laws of probability.

The chief condition for recovery from syphilitic brain disease is a very energetic and long continued course of mercury combined with potassium iodide. For this the inunction treatment is the only one possible. The treatment demands the greatest carefulness. This intensive treatment must be continued, or resumed if necessarily interrupted, so long as any traces of syphilitic brain disease remain. Among these the writer places not only headache, giddiness, neuralgia, pareses, aphasia, amnesia, sharp hunger, attacks of laughing and crying, diabetes of both kinds, and similar easily diagnosed symptoms, but also mental disturbances, down to a degree of weakness that can only be discovered by the writing test. He remarks that local applications, such as ice bags, three or four daily, and the constant current, are in some cases useful adjuncts and expedite improvement. Mental exercises are also sometimes useful, such as reading and writing, in cases of great mental weakness, just as gymnastic exercises are in locomotor ataxy. What strikes the observer most, however, in recovery, which often requires years for its fulfilment, is the conviction that brain syphilis, just like the total of the symptoms of constitutional syphilis, even when it appears to be mild in character, should be treated with all possible energy, as he lies the best method, both as regards the brain disease itself and also as regards prophylaxis.

## The Operating Theatres.

### HOSPITAL FOR SICK CHILDREN, GREAT ORMOND STREET.

OPERATION FOR ILIAC ABSCESS.—Mr. KELLOCK operated on a girl, æt. about 4 years, the subject of tuberculous caries of the lower dorsal region of the spine. An abscess had developed in communication with this, and was occupying the right iliac fossa, but had not extended below Poupart's ligament. The incision was made in the right inguinal region about an inch above, and parallel to, the outer third of Poupart's ligament; the skin and muscles of the abdominal wall having been divided in the line of this incision and the subperitoneal tissue exposed, this last was pushed back with the peritoneum, so that the finger could be passed down to the abscess; it was found to occupy the greater portion of the iliac fossa and to be situated deep to the iliac fascia. Retractors having been placed in the wound, the abscess was brought into view; an incision was then made through the iliac fascia, and a considerable quantity of tuberculous material escaped. The cavity of the abscess was next examined with the finger and then thoroughly scraped out with a sharp spoon, which brought away a large amount of pulpy granulation tissue. The cavity was then irrigated with a considerable quantity of 1-6000 perchloride of mercury solution, and subsequently with sterilised water, being afterwards dried as com-

pletely as possible by means of small swabs passed in by long pairs of forceps. The opening in the iliac fascia was first closed by means of three interrupted silk stitches, and the muscles of the abdominal wall brought together layer by layer with sutures of the same material; a continuous horsehair stitch closed the opening in the skin which was then dressed with collodion and gauze. Mr. Kellock said that the great point to be noticed about the operation was the way in which the cavity of the abscess had been closed. He pointed out that it was just as important in dealing with collections of tuberculous material as with healthy structures to preserve rigid asepsis. To do this the avoidance of drainage of such cavities was important, and to prevent the track of the operation wound becoming tuberculous it was essential that before closing the superficial structures firm sutures should be put in the iliac fascia. When the tuberculous material had been removed from these abscesses the walls fall together, and the cavity as such ceases to exist; in the most favourable cases no re-collection takes place; even should this occur the contents are generally quite fluid and can be removed by aspiration, or, if necessary, the operation can be performed again. Mr. Kellock further pointed out the enormous difference to these patients whether after operation primary union in the wound was obtained, or whether the wound broke down and became infected; in the latter case a sinus would persist for years, possibly the bone trouble in the spine would become septic, and the patient condemned to a long period of suppuration and danger, which can thus be prevented by the avoidance of drainage and the observance of the most strict antisepsis.

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## The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, OCTOBER 23, 1901.

### FLAWS IN REGISTRATION.

REGISTRATION, in its general application, may be regarded as a first step in the great science of preventive medicine. Without its aid there would be no possibility of arriving at the facts of the birth-rates and the mortality rates, not to mention the relative destructiveness and prevalence of various

diseases, infectious or otherwise. Indeed, registration as applied to public health is the corner-stone of the foundation upon which is erected the edifice which is of such vast importance to the community. It behoves the medical profession, therefore, to keep a watchful eye upon the registration of births and deaths, as well as the notifications of infectious disease and the vaccination returns, for both of the latter are virtually registrations. With regard to the present methods of administration it can hardly be said that they have attained perfection, either in their thoroughness or their universality of application. The area covered by the notification of certain communicable diseases, for instance, is ludicrously inadequate, inasmuch as it fails to include measles, whooping-cough, and diarrhoea, which rank among the most deadly of the zymotic diseases in the United Kingdom. The vaccination returns are upon the whole satisfactory, but a recent incident in connection with the epidemic that has for the present secured an apparently firm foothold in London, has shown that the field of vaccination is practically limited by the extent of birth registration. To put the case objectively, a family of four or five unvaccinated children were discovered to be suffering from small-pox. Inquiry showed that they had not been brought under the notice of the Vaccination Officer, because their births had not been notified for the purpose of registration. The registration of births is a duty left to the parents, and failure in that respect renders them liable to a penalty of five pounds. No machinery is in existence, however, for finding out if the law is evaded, and in the instance above quoted there has clearly been no difficulty in avoiding the obligation, an omission which was brought to light by the merest chance. In some cases the non-registration of birth is discovered when the child reaches school age and comes under the control of the school board. It is then the duty of the school authorities, if there is no certificate of birth forthcoming to communicate with the registrar, by whom a prosecution is, or ought to be, enforced. A check of that kind, however, is dilatory, uncertain, and especially undesirable, from the fact that it throws the onus of prosecution upon vicarious shoulders. Moreover, in the case of which such frequent allusion has already been made it was of no value whatever, as some of the children were actually attending a board school. It seems clear, then, that some sort of house-to-house visitation is needed, at any rate in crowded centres of population, in order to ascertain that all births have been duly notified. With regard to deaths there is need for a great deal of reform. The Registrar-General's department might by a stricter revision of death certificates exercise a great check upon unqualified practice. At the same time it is only fair to say that a great deal has been done of late years in that direction by local registrars. Then the verification of death by the certifying medical practitioner should be insisted upon, as well as a statement of the duration of attendance on deceased. This service on the

part of the medical man should be paid for by the State, which would thus be in a position to attach conditions to the process of certification. As things go, the State demands and the public have learned to regard as a gratuitous right the granting of a responsible legal document by the medical man. The whole question of death certification is a wide one, and its full discussion would be beyond the scope of the present article. Enough has been said, however, to show that the reform of death certification is a social matter that presses for Parliamentary attention. When the nation has time once more to turn its attention to domestic affairs it is to be hoped that a short but comprehensive measure will be passed to amend the flaws in the present system of the registration of births and deaths, upon the efficiency of which largely depend the progress and the security of public health administration.

#### THE EXTRA-MURAL SCHOOLS OF THE SCOTTISH UNIVERSITIES.

It was well-nigh inevitable that many people should be dissatisfied with any arrangement that might be settled in connection with the magnificent gift of Mr. Carnegie for the advance of education in Scotland. It requires little argument to show that unless the greatest care and foresight be exercised the amount of benefit to education to be derived from even a large sum of money may be very greatly minimised, that indeed such a subsidy may produce retrocession in certain directions. A plea on behalf of the extra-mural schools in Edinburgh and Glasgow is very ably put forward by Dr. R. J. A. Berry, in the September number of the *Scottish Medical and Surgical Journal*. According to Dr. Berry, no fewer than one-third of the medical students of Edinburgh and Glasgow Universities receive instruction outside the Universities; not from the Professors but at the extra-mural schools. At neither Aberdeen nor Dundee do such schools exist. It is a pity Dr. Berry did not include statistics showing the total number of students taught in the extra-mural schools, and also the number taught in the Universities. He says there has been a steady decrease in the number of students coming up for Scotch degrees, especially at Edinburgh, and that this decline was manifest before the five years' curriculum was established. Not only do one-third of the University medical students of Edinburgh and Glasgow go to the extra-mural schools to be taught, but the number has been steadily increasing. Dr. Berry seems to attribute this extraordinary state of affairs to the undermanning of the teaching staff and the overcrowding by the students at the Universities, this congestion of students being due to the reputation of the Professoriate. The prosperity of the extra-mural schools would from this appear to arise from their being used as a sort of overflow from the University class-rooms and theatres. On the other hand, Dr. Berry, referring to the extra-mural teachers, affirms that "In almost every department of medicine . . . are to be found men of

European reputation literally working for their lives against their own poorly equipped and undermanned University, as the latter knows to its own financial cost." The question is, then, anticipated, "Why, then, do not the Scottish universities increase their staff?" . . . and the answer given is, "Want of funds," but many will scarcely be convinced by this answer. According to Dr. Berry's showing the University allows students to go to rival institutions bringing with them the money which ensures the vigorous life of the opposition, because, forsooth, the Universities have not money wherewith to provide a sufficiently large teaching staff. Surely if the Universities be overflowing with students they should be able to increase their teachers so as to be able to cope with the work required of them without pleading for charitable assistance. Dr. Berry finds a solution of the difficulty presented by the unfair disadvantage the extra-mural schools will in future suffer from in consequence of the subsidising of the Universities in a scheme of amalgamation which he believes might be effectively carried on with the aid of another £50,000 a year. It is remarkable that this article should be followed by another in the same journal entitled "Difficulties in the Way," from the pen of Dr. D. D. Buchan, in which the following passage occurs:—"It is perhaps unfortunate that the Universities Commissioners found it necessary to put the professors on fixed salaries, and to remove entirely the very obvious incentive of payment by results through the class fees." He recommends *work* (the italics are Dr. Buchan's) as a cure for luxury and laziness on the part of the teachers. Having laid down a scheme by which he thinks this might be brought about, he says, "Whatever may be the justice of current complaints of professional sterility, such could, under the scheme indicated, not long endure."

#### THE DELIVERY OF THE PLACENTA.

PROFESSOR A. R. SIMPSON has lately brought into prominence once more the long-disputed question of the origin of the method of effecting the delivery of the placenta by external manipulations. To this method—a method the introduction of which was one of the historical advances of midwifery—has been attached by some the term "The Dublin Method," by others the term "Crédé's Method." Dr. Simpson proves himself in his article to be an upholder of the latter title, but we cannot think that he has advanced any proofs of great weight in support of his belief. In the main, he quotes from two authors in support of his contention—M'Clintock and Churchill. M'Clintock, who was one of the first to point out that the method subsequently introduced into Germany by Crédé had been practised "from time immemorial" at the Dublin Lying-in Hospital, would at first sight not be a very promising witness on Crédé's behalf. Dr. Simpson, however, endeavours to destroy the value of the evidence which M'Clintock and Hardy's "Practical Observations" afford (1848) by the remark that the paragraph—which to our

mind describes the method of placental expulsion exactly—"discusses the management, not of the third stage, but of special cases." And this he states because the paragraph in question is headed "Hæmorrhage between the birth of the child and the expulsion of the placenta." It is, however, the only place, so far as we can determine, where any method of obtaining the delivery of the placenta is discussed save in cases where manual removal is necessary, and consequently may justly be regarded as describing the treatment adopted in normal cases. Dr. Simpson prefers to rely on the teaching of Churchill, "as a representative of the Dublin school," but Churchill definitely says: "Before applying the binder . . . the uterus should be firmly grasped and firm pressure made in the direction of the axis of the brim. In most cases, as the placenta has been detached by the last pains, it will be felt to recede under the hand, and the after-birth will be found in the vagina or bed. . . . If not we should make firm, but steady, and not excessive, traction by the cord." This, to our mind, is very negative evidence in favour of Dr. Simpson's contention that traction upon the cord was associated with expression in the "Dublin method." It appears to us to say plainly, only in other words: "Express the placenta; if this cannot be done, pull upon the cord." The question of pulling on the cord or not—in case of the failure of expression—has nothing to say to the question of who originated the method of delivery by expression. There are some writers who state that Credé's method differs from the Dublin method in that it is adopted at an earlier or later period in the third stage of labour. There are others who find that Credé's method differs in that it is more severe or less severe than the Dublin method. These points, however, are mere matters of detail—changes in technique which have been introduced from time to time, but which have nothing to say to the method as a method. Credé's method and the Dublin method are terms applied to the delivery of the placenta by external manipulations, as opposed to its manual removal or its delivery by traction on the cord. In the Dublin method "the organ must be grasped firmly and pressure exerted upon it in the axis of the pelvis" (M'Clintock, 1848). In Credé's method, "we seize with one or two hands the fundus, and when the contraction arrives at its maximum intensity we press upon the fundus and the walls of the uterus, at the same time driving it down into the small pelvis" (Credé, 1853). The whole question is one of priority, and reference to the literature of the period will, we think, clear it up. The Dublin method was brought prominently before the notice of medical men twelve years (1848) before Credé brought a similar method prominently before the medical world in Germany (1860). In Dublin the method had been practised at the Dublin Lying-in Hospital "from time immemorial." In Germany, Credé had taught its value clinically for seven years. Credé is fully entitled to the credit of having evolved his method *de novo*, but he is not entitled to the credit of being first in the field.

## Notes on Current Topics.

### Casting out the Mote.

WE heartily congratulate the Pharmaceutical Society of Ireland on the very sensible and practical address of their President, Mr. Beggs. His apologetic statement that it was want of time alone prevented him from reading a scientific paper was unnecessary. For the encroachments of the grocer and draper and quack medicine vendor on the rights and privileges conferred on the Pharmaceutical Society of Ireland by Act of Parliament Mr. Beggs had more than enough for his opening address. He compared the activity of the Inland Revenue authorities in hunting down delinquents; they allow none to escape—no fish is strong enough to break their net or so small as to slide through its meshes. Right loyally he criticised the mistaken sympathy that the local magistrates in Ireland bestow on druggists who are caught illegally compounding prescriptions, not being licensed to do so, and he urged on the Society the wisdom of seeking power from Parliament for dealing with the evil. In all this he is worthy of the warm approval of the Society. It is his duty to see that the rights of the licentiates shall not be filched away from them, and magistrates should come to recognise that the law is for the public good and ought to be properly put in force. Patent medicines and proprietary preparations he mentioned simply to be condemned. The President cannot see why the local pharmaceutical chemist cannot put up his own preparations. Why not stock his glass cases and counters with his own remedies for indigestion, anæmia, bronchitis, tuberculosis, rheumatism, sore eyes, sore nipples, epilepsy, and every other ill that flesh is heir to? We quite agree with him that the quackery of the local pharmaceutical chemist is as dangerous as that of the wholesale manufacturer. Blank's nostrums are quite on a level with the Trench remedy or the Sequah magic cure, and are all alike to be condemned. There are, nevertheless, some proprietary preparations of known formula that the manufacturers have attained to excellence in their production that other firms have not equalled; with these we think the local pharmaceutical chemist cannot compete, and from the experience of the medical profession with such we believe the prescriber will favour them. There is yet another Richmond in the field—the itinerant vendor of drugs, who attends country fairs to sell his "blessed unguents, rare extractions. To fortify the most indigest and crude stomach"—who, possessing a tongue like Scot's Mantuano, diverts custom from the prescribing pharmaceutical chemist of whom the worthy President made no mention in all his enthusiastic defence of the rights of their licentiates. He warmly defends "*meum*," but we fail to see any acknowledgment of "*tuum*." In firm, unmistakable language he calls for the prosecution of the grocer or draper who would sell a bottle of chlorodyne or essence of linseed. For such law-breakers there is no forgiveness—their ignorance

might cause death; this is quite true. But why be silent on the many deaths that the counter-prescriber has caused through his ignorance? Will the prescribing chemist pursue his path unrebuked, happy in the thought that in casting out the mote of his brother's eye he has fulfilled the law?

#### Railway "Tube" Ventilation.

OF late a revolution has been effected in underground railway travelling by the introduction of electrical "tube" railways. One of the chief drawbacks of all subterranean roads of the kind must be the difficulty of efficient ventilation. The earlier underground railways are still rendered noxious by the sulphurous smoke from the engines, together with the fumes and mephitic vapours that are associated with passages burrowed in the bowels of the earth. The electric "tubes" are free from sulphurous fumes, it is true, but they have a peculiar odour and stuffiness of their own. The fact of the matter appears to be, to put the thing shortly, that the engineers of the last Metropolitan undertaking—commonly known as the "twopenny tube"—have not paid sufficient attention to the all-important question of ventilation. There is at most of the stations a winding staircase, which, however, will not act as a ventilating shaft unless means are taken to establish an extracting draught. Even the lifts, which by their constant to-and-fro passage would serve to some extent to cause a circulation of air, are rendered practically useless by the closely-fitting entrance and exit doors placed both at the upper and the lower levels. The top panels of these doors are glazed, and we would respectfully suggest to the directors that the glass be at once removed. There should be no difficulty in securing perfect ventilation of these "tubes" with suitable appliances. The train nearly fills its tunnel, and propels before it a great mass of air, which by a little management could easily be directed through up-cast shafts. Independent air inlets and outlets are clearly required at proper intervals. Before long the "tube" system is sure to be adopted in many of the great towns of the United Kingdom, so that it is well to be forewarned as to a grave defect.

#### Artificial Hospital Debts.

EVER since the management of medical charities attained the dignity of a fine art it has been recognised as a leading principle that every such institution should have its own debt. For some occult reason the rules of ordinary business-like thrift and prudence do not apply to the average charitable hospital or infirmary, at any rate so far as the adjustment of income to expenditure is concerned. In this connection the *Western Mail* of October 10th has some stringent criticisms upon the financial arrangement of the Cardiff Infirmary. From the report recently adopted by the Board of Management we gather that, by closing the books earlier than usual, certain subscriptions would be pushed over into next year's account. The sum thus dealt with is stated at

£2,000 by the *Mail*, and after applying £1,118 contributed by a special fund to meet the balance on the income account, the result is a nominal balance of £114, which, according to the chairman, is all that is in hand for the carrying on of the work of the institution for the next three months. Were that the case then the affairs of the Cardiff Infirmary would indeed be in a parlous condition. The chairman, however, quickly re-establishes confidence by the usual appeal for contributions. The *Mail* calls these methods of finance "devious," and there certainly appears to be some little justification for the taunt. "Although nothing could be clearer," it remarks, "than the policy which the Committee ought to adopt in order to keep the institution out of debt, the members persist in turning into bye-ways, in order, apparently, to accumulate liabilities which are certainly preventable if ordinary prudence and foresight are observed." This is the sort of finance almost universally adopted by the "business" men who think medical men should be excluded from hospital management.

#### Bacelli's Treatment for Tetanus.

ONE of the most disconcerting features of therapeutical research is the curious divergence in the results obtained by different observers. Thus a method which has given what may, without exaggeration, be called brilliant results, in the hands of another has no success at all, or even proves injurious. Bacelli's method of treating tetanus, which consists in the injection of carbolic acid, has been highly spoken of by experienced observers in various parts of the world, and we were entitled at one time to hope that a remedy of some value had been made available in the treatment of a disease which has proved refractory to every kind of medication, not excepting the fashionable serum. Some contradictory experiments carried out on goats by Dr. Josias, of Paris, with this agent, and brought before the French Academy of Medicine, seem to show that carbolic acid is rather harmful than otherwise. Dr. Josias, having ascertained that two grains per kilogramme was a lethal dose of tetanus virus in respect of goats, injected 2 cc. of a 2 per cent. solution of the acid as soon as the characteristic symptoms of tetanus made their appearance. Far from checking the further evolution of the symptoms the animals which had received the carbolic acid injections succumbed more rapidly than the other inoculated animals. Even more remarkable is the fact that the inoculated animals appeared more susceptible to the toxic action of the acid than normal healthy animals. It will be noted that the test consisted in injecting the acid *after* the appearance of the symptoms, and we are left in doubt as to the effect of injections made concurrently with the inoculation or soon after. In practice, of course, it is hardly possible to institute any anti-tetanus treatment until the symptoms point to infection, and this is why even the serum, which confers immunity if injected beforehand or even concurrently, fails to afford relief after the poison has gained a firm hold on the organism.

### The Injection of Quinine.

It is stated in a well-known text-book of medicine that the hypodermic injection of quinine is the most effectual and economical way of treating malarial fevers, and what is known as Benson's method is strongly advocated. Benson's method is reported to have been adopted in over 1,385 cases, and in these the form of quinine used was the sulphate dissolved in water with the aid of hydrochloric acid in the proportion of fifteen grains to the drachm, twenty minims being injected into the outer surface of the arm. In 614 consecutive cases treated in this manner one injection usually sufficed, and not a single untoward accident occurred. Dr. R. M. Townsend, of Buluwayo, has had a very different experience. The site of the injections in his cases became sloughy, and in one instance, in which the patient was also receiving hypodermic injections of strychnine, the sites showed no signs of inflammation whatsoever. Dr. Townsend's views are also borne out by the evidence of Mr. James Cantlie, who protests against the method of treatment. Many medical men who have abandoned the subcutaneous injection of quinine on account of the inflammatory trouble which resulted, have been accused of want of cleanliness and care, and this charge has up till now effectually silenced any attempt to call attention to the formation of abscesses following the injections. Mr. Cantlie records that he saw several persons in Hong Kong with abscesses on the outer aspect of the left forearm, who had all been treated by a French physician practising in a French possession near Hong Kong. The severity of the resulting abscesses may be judged by the fact that they are reported to have penetrated deeply through the deep fascia with serious ulceration. Healing is very slow, and permanent disfigurement is by no means an uncommon sequel. Though this matter cannot be termed one of extreme urgency, it is, nevertheless, of sufficient importance to justify our questioning the advisability of adopting this method.

### The Proposed Malaria Cure for Cancer.

It may be confidently anticipated that sooner or later the cure or, better still, the prevention of cancer will be brought within the grasp of scientific medicine. A host of observations have been made as to the racial, geographical, climatic, geological, and other aspects of the distribution of the malady. Among various striking facts is the high degree of immunity enjoyed by malarious countries, amounting practically, so it was stated long ago by Professor Trinká, of Hungary, even to total freedom. That statement, however, would have to be accepted with caution, and only after a careful definition of what is meant by the term "malarious" as applied to a district. The idea, however, has been recently revived by Professor Loeffler, of Greifswald, whose name is so well known in connection with the famous Klebs-Loeffler bacillus of diphtheria. He advocates the possibility of curing cancer by injecting patients suffering from that malady with blood taken from malarious persons. He further suggests that the

trial should be made at once in hospitals in all parts of the world. Should there prove to be any real foundation for his induction he will achieve a triumph indeed, for it would be hard to imagine any greater benefactor of the human race than the discoverer of a cure for cancer. The plea for the endowment of state laboratories fully equipped for scientific medical research in all its ramifications could hardly find a better justification than in our present ignorance of the ultimate pathology of so common and so fatal a disease as cancer, and our helplessness when called upon to stay its ravages.

### Epidemic Jaundice.

EPIDEMICS of jaundice, although not unknown, are by no means of frequent occurrence. Special interest therefore attaches to an outbreak which is being investigated under the instructions of the Local Government Board at the villages of Poolbrook and Speedwell, near Staveley. A somewhat similar outbreak is recorded as having occurred at Rotherham about a quarter of a century ago, described as epidemic catarrhal jaundice. On that occasion, however, the febrile phenomena were marked, whereas in the present epidemic fever has not been a prominent symptom. Its infective nature is shown by its having been carried to neighbouring districts by persons suffering therefrom, and it is a noteworthy fact that males suffered more than females, in the proportion of three to one. The outbreak commenced during the hot weather in August, the first indication of infection being extreme drowsiness and lassitude, sometimes amounting to prostration, associated with aches and pains all over the body, suggesting an attack of influenza until the supervention of the jaundice cleared up the diagnosis. The total number of cases is about 300, but only three proved fatal. The average duration of the malady was about a month, this being about the same as in catarrhal jaundice of the ordinary non-infective kind. It is authoritatively stated not to be due to the defective water supply, but doubtless we shall be better able to form an opinion on this point when the inspector issues his report.

### Permanganate of Potash as an Antidote for Morphine Poisoning.

THE value of the discovery of the antidotal properties of permanganate of potassium in cases of poisoning by opium and its derivatives has been somewhat discounted by contradictory reports from various sources. Every case in which this drug has been tried is, therefore, of interest. One such is published in a recent number of the *N. Y. Medical Record*, by Dr. Leonard Weber, of New York. The victim was a very obese man, thirty-eight years of age, who had received a hypodermic injection of a third of a grain of morphia soon after having swallowed two powders, each containing a sixth of a grain of the drug. He promptly fell into a comatose condition, and respiration became imperceptible. The injection of two grains of the

permanganate, in divided doses, brought him round, and he eventually recovered. The case, as reported, is not absolutely convincing, because an interval of an hour apparently intervened between the injections and restoration to partial consciousness, and the usual methods were also resorted to. The author insists on the value of the hypodermic method in addition to administration of the salt by the mouth, and this view commends itself since the salt taken by the mouth cannot do more than neutralise by oxidation that portion of the alkaloid which has not undergone absorption.

#### "A Lethal Coin"—Was it Radiographed?

A CORRESPONDENT, referring to the case mentioned in our last issue of a working man operated upon at the York County Hospital for a coin lodged somewhere in the air passages, which foreign body was not found until after death, when it was discovered in the stomach, the inference being that it had been coughed up by the patient and swallowed. Our correspondent asserts that this point could have been settled in a few minutes by an examination with the fluorescent screen, which in a matter of this kind replaces inferences that are open to dangerous fallacy by direct evidence offered in objective form to the senses of the observer. Has the York County Hospital no Röntgen ray apparatus, he asks, and if not, why not? We have no hesitation in saying that any modern hospital which is not equipped with a proper set of X-ray apparatus and the services of a competent radiographer cannot do justice to its patients. Instances of coins and other foreign bodies detected in the trachea, gullet, and alimentary canal are reckoned by scores and hundreds. A reference to the last edition of Dr. Walsh's book "The Röntgen Rays in Medical Work," will furnish a variety of interesting information on that and kindred points. The fact of the matter is that the Röntgen methods have placed in the hands of medical men an additional weapon of exact diagnosis. Any surgeon who endeavours to treat on purely clinical grounds a patient who is said to have swallowed a coin, the whereabouts of which is not absolutely clear, is not working with the best available tools. Not only should every medical institution have a good set of modern apparatus, but should also secure the help of a competent medical man as an expert operator.

#### The Present State of the Carcinoma Question.

IN an interesting paper from the pen of Dr. Senn, of Chicago, published in a recent number of the *Journal of the American Medical Association* the author reviews the literature of the subject and discusses the lines on which future researches should be conducted. If carcinoma is, as we have every reason to believe at the present time, the produce of an erratic cell proliferation beyond the limits of the influences which preside over and regulate normal tissue growth, it appears rational to search for some remedy which would affect the parenchyma of the

tumour in one of two ways: 1. An agent or agencies which would destroy the epithelial cells by causing speedy and early degeneration of the imperfectly developed epithelial cells. 2. The employment of a local or general remedy or remedies possessing the power of converting embryonic into mature epithelial cells. Ligation of the principal arteries supplying the tumour tissue with blood, and the employment of sclerogenic substances have been resorted to for the purpose of accomplishing the first object, but so far only with indifferent results. Very little, if anything, has been accomplished in the conversion of the low type of epithelial tissue into mature tissue, that is, in transforming a carcinoma into a benign epithelioma. It is, however, not beyond the range of possibilities that future experiments and observations will open up a wide field of usefulness by the discovery of agents capable of exerting a beneficial or curative effect on the essential tumour elements, by inciting degenerative processes, or by converting them into tissue of a higher, mature type.

#### Latent Fibroids.

IT is not an uncommon experience for an operator to dilate the uterine canal and attempt the removal of submucous fibroids. However carefully the procedure be conducted, and no matter how thoroughly the walls of the cavity are examined for minute fibroids no honest assurance can be given to the patient that other fibroids will not grow in her uterus. This subject of latent fibroids has lately been a matter of careful investigation and study by modern gynecologists, and the views of Mr. Bland-Sutton though not universally accepted by all his colleagues, certainly stand the brunt of criticism. Botanists apply the adjective "latent" to buds which remain undeveloped or dormant for a long time, but may at length grow, and it is precisely in this sense that the word "latent" is used by Mr. Bland-Sutton when pointing out the significance of latent fibroids in regard to the operative treatment of such tumours. Careful consideration of the great frequency of seedling fibroids, and their multiplicity when compared with the number of fibroids which attain proportions sufficient to render them clinically appreciable, makes it undeniable that an enormous proportion of them remain latent. The fact that they may remain dormant through a long life, or assume active growth and become formidable tumours shows that they may very appropriately be compared to "latent" buds. One observation that has been made by Mr. Bland-Sutton is that pregnancy may exert a quickening influence on latent fibroids, and in his practice he has enucleated fibroids from the uterus on very many occasions; in four of the patients there has been a recrudescence of the fibroids which has necessitated a second operation. Similar cases have occurred to other surgeons, but there is very little trustworthy information available to enable even an approximate estimate of their frequency to be made. Under certain conditions, which easily suggest themselves to

the minds of those who are engaged in performing these operations, this may have a very important bearing when an operator is deciding whether to be content to enucleate a uterine fibroid, or whether it is best in the interests of the patient to remove the uterus.

#### Enteric Fever.

THE opinions of those most capable of forming a correct judgment on the question of the efficiency of inoculation against typhoid fever, are gradually becoming known to the medical public, sometimes by written communication to the papers, and sometimes by word of mouth in the course of the clinical teaching. Dr. J. W. Washbourn, who has had a very wide experience, in the course of his duties in South Africa, of the effects of enteric fever on soldiers, nurses, and civilians, pointed out in the course of a clinical lecture delivered at Guy's Hospital, that the theory of typhoid inoculation is that which corresponds to a mild attack of the disease is produced, and the idea is that this mild attack will protect against another attack. Inoculation against typhoid fever consists in injecting the dead product of the bacilli into the body. With regard to the practical results of inoculation, Dr. Washbourn's experience is that it is of very little value, and he is quite satisfied that it does not modify the course of the disease. He has not observed any material difference in the nature of the attack between the inoculated and the non-inoculated. The fact that enteric fever does not protect to the extent that was previously thought must, it appears, be accepted as the explanation of the unsatisfactory results from inoculation. To a very great extent one attack of enteric fever may be said to protect against a second, but it certainly does not protect absolutely. Although in England a person rarely gets a second attack of enteric fever, in South Africa second attacks are not uncommon. The reason appears to be that exposure to infection is greater in South Africa than in England.

#### Leadless Glaze.

THERE can be no more terrible toll paid to capital by labour than that exacted by lead poisoning from the worker in china and enamel ware. Yet not only is poisoning of the kind preventable, but it is absolutely wanton and unnecessary. It has long been known that a perfect glaze can be obtained without the use of a particle of lead. Some of the modern Worcester ware turned out by Messrs. Hadley, for instance, has a beautiful soft gloss procured solely from leadless glaze. How, then, is plumbism to be abolished from our china and enamel factories? Clearly, reform is not to be looked for from the spontaneous action of employers. Nor is it to be expected from the influence of purchasers, who rarely interest themselves in anything concerned with the production of the articles they require. The only apparent hope lies in legislative action which will make it illegal for the manufacturer to use lead, in any shape or form, to the detriment of

his workpeople. For all that, it may be noted that Dr. Thorpe, the Home Office authority on this subject, says that the matter may be settled by the public, if only they will insist on being supplied with leadless glazed china. Here, at any rate, is a simple way in which the women of the United Kingdom may with little effort do a great deal towards rescuing many of their countrywomen from a terrible risk. As everyone knows, the worst cases of plumbism are commonly met with in young women who are susceptible to the poison.

#### Leukæmia and Pregnancy.

LEUKÆMIA is a condition associated with enlargement of the spleen, and women who are suffering therefrom obviously run certain special risks in connection with pregnancy. Apart from the possibility of rupture of the spleen in the event of comparatively slight traumatism, these women experience, as one might expect, much greater discomfort from the abdominal distension associated with the development of the uterus than is usual. The leukæmia itself is intensified by pregnancy, and this creates a liability to abortion or premature labour. These points were very clearly brought out at the last meeting of the Obstetrical Society of London in a paper by Dr. G. Herman on this subject, and the conclusion he arrived at is that when pregnancy is complicated with leukæmia the indication is to empty the uterus. The procedure is not unaccompanied by risk because of the danger of uncontrollable hæmorrhage; indeed, when death takes place it has generally been attributable to this cause.

#### The Influence of Spermotoxin on Reproduction.

THE therapeutical arsenal comprises a plethora of aphrodisiac agents or reputed such, but there is a lack of substances which exert an inhibiting effect on the reproductive functions. We are not aware of the existence of a demand for either class of agents, but as a matter of scientific curiosity we may note that spermotoxic serum obtained from the guinea-pig, if injected into mice, inhibits reproduction for a period of three weeks or thereabouts. If, however, the serum be deprived of its alexin constituent no such effect is produced. The serum does not act by inhibiting the secretion of semen, the artificial sterility being probably of nervous origin. We are unable for the moment to suggest any practical application of these interesting observations, anaphrodisiacs not commanding a ready sale in the Eastern Hemisphere.

#### Diabetes in Infants.

DIABETES in infants is not very frequently met with but when this disease does attack the young it usually runs a very acute course. By a curious coincidence two inquests have been held at East Ham within a few days of each other on children who had succumbed to this malady. One was a female child, two years of age, and the other, also a female, was somewhat older. In the first case there was a history of diabetes going back at least



eighteen months, and the child suffered from frequent epileptiform attacks presumably of uræmic nature. So protracted a course is scarcely compatible with the text-book description of "acute diabetes."

#### Water Supply and Pollution of Rivers.

IN the course of the discussion on water supplies and river pollution which took place at the Conference held by the Sanitary Institute on October 17th, several speakers referred to a passage in Dr. Rideal's paper, in which he said that the most important point in judging of the purity of a water supply at the present time is certainly the typhoid fever death-rate and next to it the general bacterial purity of the water. Mr. Caink, of Worcester, attempted to inform the Congress of his experience on this very point of the typhoid fever death rate, but for some reason or other a portion of his audience declined to allow him a hearing. Those who were near enough to him found that he had something very interesting to talk about, and it is worth recording. The City of Worcester before 1894 had an indifferent water supply. Since 1894 the water supply has been excellent. Before 1894 the typhoid case rate in Worcester was about 50 per cent. above the average case rate of the principal towns throughout the kingdom. The number of cases of typhoid for the winter part of the four years preceding March, 1894, when the improved water supply was instituted, averaged in Worcester fifty-two. This number fell during the half-year ending March, 1895, to six, and this remarkable drop has with very slight exceptions been maintained ever since. The City of Worcester must be congratulated on this satisfactory state of affairs, and we are glad to put the facts on record because they are not only important in confirming Dr. Rideal's views, but they also have a wide practical bearing.

#### Ringworm in Schools.

A VERY pressing question demands settlement in connection with the prevalence of ringworm in the London schools. At the various hospitals for diseases of the skin it has been noticed that the majority of the subjects suffering from this condition contracted their ringworm in the board schools. So pronounced has the evil become that Dr. Phineas Abraham made a special point of drawing attention to the subject in the course of his remarks to one of the post-graduate classes at the West London Hospital. The time has certainly arrived when something should be done in the matter. We quite agree that it is not fair that poor people should be forced by law, as they are, to send their healthy children to institutions where there is a risk of their contracting such a disease. Under the present system infected children may, and often do, attend schools for weeks or months and spread ringworm, pediculosis, &c., unchecked. The obvious remedies are that in the first place provision should be made for periodical medical inspection. The suggestion made by Dr. Abraham that all cases of ringworm should be isolated from healthy children and taught in separate

rooms from the others is a perfectly reasonable idea, but we fear that the proposal is a little too drastic for it to have much chance of immediate adoption.

#### The Medical Service at St. Paul's.

THE annual medical service at St. Paul's Cathedral, organised by the Guild of St. Luke, attracted a very large attendance of members of the medical profession, a great number of whom donned their robes for the occasion. The number of women doctors was strikingly large, and a large proportion of them showed by their academic gowns that they were graduates of universities. The scene from the seats at the end of the choir was a very striking one. The music was rendered by the London Choir Association under the conductorship of Mr. H. Walford Davies, organist of the Temple Church, and the selection of the music was admirable. The sermon, preached by Canon Gore, was an appeal to members of a great profession to realise the responsibility of their calling. Canon Gore drew a striking parallel between the work of the parish priest and that of the doctor. Though controversial matter was touched upon when he suggested that only the opinion of the expert in either profession could be taken as law, the sermon was of thrilling interest, and was listened to very closely by the congregation.

#### A Just Punishment.

"A CANCER curer" at Dunedin, New Zealand, has been fined £50 for assuming the title of doctor of medicine. Mr. Wm. Stanton, the person in question, was doing a large practice, and as is the custom with such persons, issued thousands of handbills telling of the wonderful cures his remedies effected. His most striking statement was as follows:—"Where Dr. Stanton fails to relieve pain, or cure disease, other medical men may stand aside and weep." On hearing the sentence of the court "Dr." Stanton immediately drew a cheque for the amount, and then notified his intention to discontinue the title "Dr." and adopt that of "Professor," as he publicly teaches and exercises for pay the occupation of a "cancer curer." And so much abused has this ancient and honourable title become that he may with dancing masters, phrenologists, balloonists, jugglers, acrobats, and boxers, assume it without fear of incurring legal penalties. It is, however, satisfactory to know that the quacks' imposition on the public cannot legally be carried on under the cloak of medicine.

*Truth*, in the course of some remarks on the refusal of the magistrate to grant a summons against Dr. Purdie, the assistant public vaccinator for St. Pancras, for assault, suggests that an application should be made for a *mandamus*, or that a civil action should be taken to recover damages. We fancy the plaintiff would have some difficulty in convincing an average British jury that the children had sustained damage by being vaccinated at a time when small-pox is epidemic, but this is what we may expect when journalists take to giving legal advice gratis.

**Royal Academy of Medicine in Ireland.**

THE annual meeting of the Royal Academy of Medicine in Ireland is to be held in the Hall of the Royal College of Physicians on Friday next, the 25th inst. The session of the Academy will then commence, and the first sectional meeting will take place the following week. For many years past we have found it a matter of great difficulty to obtain the reports of the proceedings of the sections with sufficient regularity and at an early enough date to make them of interest to our readers. This, we are glad to say, will now be changed. We have much pleasure in announcing to our readers that in the future THE MEDICAL PRESS AND CIRCULAR will occupy an official relationship to the Royal Academy of Medicine. We shall ourselves be responsible for the reporting of the proceedings of the sections, and with the assistance of the sectional secretaries of the Academy we can undertake to lay the proceedings of the Academy and the abstracts of papers before our readers at a very early date after the meeting has been held. We trust that the arrangement which has been entered into between the Academy and ourselves will be a lasting one and result in mutual benefit.

**London School of Tropical Medicine.**

FROM the description supplied by Dr. Patrick Manson of the conditions under which the students work at the London School of Tropical Medicine it is quite clear, as Lord Brassey said in his opening address at the Royal United Service Institution, that the school is in need of further funds for the purpose of enlargement to enable the medical staff to carry on the work of teaching. The accommodation is so scanty that students have to either wait their turn to join or else go elsewhere. It is so self-evident that facilities should be afforded to medical men to obtain a knowledge of tropical diseases before taking up duties abroad that we hope a satisfactory response will be made to Lord Brassey's appeal for funds. The sum of £100,000 asked for seems at first sight an excessive demand, but the school is intended to supply medical teaching in tropical diseases for the preservation of the health of persons residing in the tropics, and this means a most extensive sphere of influence.

**A Vaccination League.**

THE movement for the creation of a league to promote and popularise vaccination is certainly most opportune. Its objects are to spread a wider knowledge of the benefits derived from vaccination and a better understanding among the general public of the advantages arising from preventive medicine and practical sanitation. The League already numbers among its supporters a goodly array of influential laymen interested in the subject, and numerous eminent medical men, including Mr. Jonathan Hutchinson, F.R.S., member of the recent Royal Commission on Vaccination; Sir Alfred Garrod, F.R.S., Physician Extraordinary to her late Majesty Queen Victoria; and Professor Charles Stewart, F.R.S., of the

Royal College of Surgeons. The temporary offices of the League are at 110, Strand, London, W.C.

**PERSONAL.**

SIR WALTER FOSTER will preside at a conference on the housing of the working classes, to be held at the Westminster Palace Hotel on December 3rd.

IN the grounds of the Hotel Dieu, Nantes, two busts were recently uncovered. One to M. Chassaing and one to M. Maisonneuve, by M. Guyon.

THE French are quick to honour science. MM. Pelletier and Coventeau have within the past few months been so honoured. It is not so in this country. As yet there is no statue to Sydenham or John Hunter, and Dublin is still without a statue to Bartholomew Mosse.

DR. JAMES MUGGERIDGE, formerly Lecturer in Anatomy in St. Andrews University, has been installed in the Chair of Anatomy endowed by the late Marquis of Bute.

MISS MARION ROSS, M.D., who in April last was appointed Junior House Surgeon at Maccleafield Infirmary, has resigned, the House Surgeon having resigned six weeks previously.

PROFESSOR JOHN CHIENE, M.D., F.R.C.S.Ed., will take the chair at the autumn dinner of the Edinburgh University Club, which is to take place at the Criterion Restaurant on November 13th.

SIR FREDERICK TREVES, K.C.V.O., C.B., will open the new bacteriological department at the Bristol Royal Infirmary on October 25th, and will afterwards preside at the annual dinner of the Medical School.

MR. CHRISTOPHER HEATH will deliver the Guthrie Lecture at the Westminster Hospital on Thursday, November 21st, at 8.30 p.m., taking as his subject, "The Westminster Hospital Forty-five Years Ago." Mr. Heath was appointed Assistant Surgeon in 1862, and was for some years Lecturer on Anatomy in the Medical School.

THE King has been pleased to approve the appointment of Surgeon-General W. Taylor, M.D., C.B., to be Director-General Army Medical Service, and on the retirement on the 31st of December next of Surgeon-General H. S. Muir, C.B.; that of Lieutenant-Colonel A. Keogh, M.D., C.B., to be Deputy Director-General with the temporary rank of Surgeon-General.

DR. W. B. MARSTON, of Flint, has been presented with the certificate of the Royal Humane Society in recognition of his gallant attempt to save the life of a man who was drowning in the Dee in July last. The presentation was made by the Mayor who recalled the fact that this was not the first occasion on which Dr. Marston had risked his life to save that of others.

**Scotland.**

[FROM OUR OWN CORRESPONDENT.]

**JAMES FOULIS, M.D., F.R.C.P.E.**

DR. JAMES FOULIS (pronounced as Fowis), a well-known practitioner in Edinburgh, succumbed after a short illness at the comparatively early age of 55. Although born in New South Wales, Dr. Foulis belonged

to a branch of the ancient house of Foulis, closely connected for long with Edinburgh in that the family estates lie adjacent to it—in 1634 the then head of the family had conferred upon him a baronetcy, a far-off ancestor of the late physician. Electing to enter the medical profession, Dr. Foulis, at a rather elder age than usual, began his studies in Glasgow; later in Edinburgh, where he took his degree in 1872, when 26 years of age; obtained the degree of M.D. two years after, and was elected a Fellow of the Royal College of Physicians of Edinburgh in 1888.

After graduation he chiefly devoted himself to an elaborate research into the minute anatomy of the ovaries in woman and in many other mammalia, and into the phenomena characterising development of the ova under all their eventful circumstances. This work stamped him at once as an original and able investigator, and it is a pity that he abandoned original research work to a great extent soon afterwards, and never seriously resumed it.

Succeeding to the greater part of Dr. George Keith's practice, whom he had assisted, on his retirement, Dr. Foulis soon found himself busily occupied with the cares of a large family practice; and not only kept it together but increased it.

A man, endowed with a most gracious manner and courtesy, with a gift of speech almost too plain for his profession, he had many admirable qualities, but at least one drawback, viz., the too fervid advocacy of some plan or theory without regard to environment, or nature.

**GLASGOW SOUTHERN MEDICAL SOCIETY.**—The above Society held its annual dinner in the St. Enoch's Station Hotel, on Thursday evening, the 17th inst. The President of the Society, Dr. John Stewart, occupied the chair, and was supported by Professors McCall, Anderson, Stockman, and Glenister, Dr. Bruce, of Dingwall, Dr. Cluckie, Greenock, and others. The croupiers were Drs. Macgilvray and Richmond. An extremely enjoyable evening was spent by the company, which numbered over sixty. The usual loyal toasts were proposed and duly honoured. Among the other toasts were "Our Society," proposed by the Chairman; "The University and Other Medical Schools," by Dr. Richmond, and replied to by Professor Stockman and Dr. T. K. Monro; "Our Guests," proposed by Dr. Lindsay Steven, and replied to by Dr. Cluckie and Mr. John Lindsay; "The Chairman," proposed by Dr. J. Fraser Orr, the indefatigable and much-esteemed secretary. The toast which perhaps had the greatest interest for the Society was that of "The General Medical Council," proposed by Dr. C. E. Robertson. In the course of his remarks Dr. Robertson pointed out that this was the first occasion in the history of the Society that such a toast had been put upon the list. Its appearance on the list of toasts that night was due to the fact that for the first time the Society had been honoured with the presence as a guest of the representative of the general medical practitioners of Scotland. Dr. Robertson doubted if at the present time the General Medical Council could expect that the toast would be received with the enthusiasm and sincerity which its importance ought to command. Keeping in view the reception by the Medical Council of a serious and influential deputation in June last, representing over 400 practitioners in the West of Scotland, he could not conceive how this august body could hope to possess the confidence and respect of the medical profession in the West of Scotland. He had no hesitation in saying that the constitution of the General Medical Council was unsound from the very foundation. What influence, for example, could the general practitioners in Scotland have when they were represented by only one man, and when the bulk of the members were responsible practically only to themselves? It was the general practitioners of the country who were most interested in the work of the General Medical Council, and the majority of the members should, in his opinion, be elected by them. Then assuredly would the Council attend to the wants and desires of practitioners. He coupled with the toast the name of Dr. Bruce, who had long been their worthy representative on the Council. Dr. Bruce, in replying, remarked that, in his opinion

the General Medical Council was composed of too many members, and he thought that a change was desirable in its constitution. He expressed himself in favour of altering the Council in such a way as to make one-half of its members the representatives of general medical practitioners.

**OPENING OF THE MEDICAL SESSION IN GLASGOW.**—The winter session at the University of Glasgow, Anderson's College, and St. Mungo's College commenced on the 17th inst. There was no formal introductory lecture at the University, but Dr. Gibson, Edinburgh, delivered an introductory lecture at Anderson's College, and Professor Laurie that at St. Mungo's College.

**"PASS AND PLUCK."**—At the professional examinations held recently there were more than the usual number of students "down in their luck" in pathology and medical jurisprudence. Of somewhere about fifty-eight candidates in pathology only twenty-four or thereabouts passed. In anatomy one poor fellow has come down for the seventh or eighth time! Not very long ago a very good student was plucked several times in anatomy.

**THE FORTHCOMING ELECTION TO THE GENERAL MEDICAL COUNCIL.**—It is proposed to present Dr. C. E. Robertson, Glasgow, with a requisition asking him to come forward as a candidate to represent the general medical practitioners on the General Medical Council. The name of Dr. Lindsay Steven, Glasgow, has also been mentioned in the same connection.

## Correspondence.

[We do not hold ourselves responsible for the opinions of our correspondents.]

### THE BACTERIOLOGICAL TEST.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Mr. Berdoe not having responded to my last letter has caused me some disappointment because, in the first place, I wanted to hear more as to what he had to say as a fully-fledged antivivisectionist; and in the second I had not completed my own observations owing to the consideration that I had already encroached on your valuable space. I now, however, crave leave to conclude as far as vivisection is concerned, although I intend later on to offer some remarks on the reliability of the bacteriological test, anticipating that you may kindly insert them, as the consideration of this is a matter of great importance, concerning the highest and most humble of medical men, and I may add at once that I am not altogether at variance with Mr. Berdoe on this score. So we may hope at least to run for some distance together in harness amicably, it being only the extreme views which he appears to hold to which I object. In a word, he seems to me to brush the science of bacteriology altogether on one side, as I think he entertains the idea that it does more harm than good; but I must say I felt very surprised that after his confession that he was no bacteriologist he should dare in the same breath to make the sweeping assertions which are palpable enough in his letters.

With regard, then, to the utility of vivisection pure and simple (and it will be observed that we have discussed inoculation and vivisection as though synonymous), Mr. Berdoe and myself are at complete loggerheads. I am anxious, however, to coax this gentleman, or all or any of his followers, if open to conviction, to turn from the error of their ways by means of bringing the matter before them in a purely hypothetical light, because some minds appear to me so constituted that they can readily assimilate suppositions or illustrations, something after the fashion of the infantile intelligence, whereas they become nauseated when brought face to face with naked facts.

I have already stated that I know little or nothing about vivisection—that is to say, in pamphlet or book form; but I do feel sufficient confidence in my own intuitive faculty to know that it serves a very valuable purpose, and notwithstanding I am placed at considerable

disadvantage in this respect (*i.e.*, not having read the subject) with the antivivisectionists I must rely on hypothetical reasoning, as Mr. Berdoe rejected the beef tea experiment on the ground that the results in animal and man are not identical.

To begin with, therefore, as an example, I believe that the operation commonly known as extirpation of the entire stomach has been performed on one or two occasions, and possibly more since I read the accounts, although not certain on this point. Let us suppose, therefore, that the bold surgeon who first conceived the feasibility of the performance upon turning matters over in his mind is confronted with a physiological doubt as to whether the viscus in question is a vital organ or not; in other words, whether, in the event of recovery from the actual operation, the digestive functions could be sufficiently carried on along the intestinal tract as to prolong life for a sufficient period to warrant the operation; and supposing further, with a view of arriving at some decision on the point, the surgeon consults physiologists, the latter, however, being unable to decide the question of hand, resolve to test it by having recourse to vivisection and in consequence the physiologists give in order to vivisectionists to narcotise and open, say, a dozen sheep and await events. And let us suppose still further that the majority of these sheep survive the operation or the immediate effects thereof, and graze about as usual, yet after a short period they suffer from an atrophic condition of system and ere long die.

I now ask Mr. Berdoe or other antivivisectionists, to adopt the vocabulary of the former, whether they consider the results of this experiment of "infinitesimal" use? Surely the experiment would, to say the least, afford evidence to a very light degree of probability that the viscus in question is essential to life, and hence a vital organ, whereas, on the other hand, supposing these sheep had permanently recovered it would to an equal degree of probability prove the reverse, and I venture to say that any surgeon on the face of this evidence, if endowed with common sense, which some very able men do not possess, the surgeon would be deterred from undertaking the operation except for the purpose, perhaps, of giving temporary relief from suffering.

I now conceive the antivivisectionists attempting to upset or invalidate my hypothesis by advancing an objection to the analogy between the sheep and man, inasmuch that they might contend that the diet of a vegetating animal is, as in the case of sheep, so different from man, that although the digestive function in one case, *viz.*, the sheep, might not sufficiently replace the function of the stomach to retain life, nevertheless it would not follow that this would be so in man, owing, as I have said, to the difference of diet, and I am ready to admit that this objection weighs to some degree against the exactitude of the analogy; but when we consider, as I apprehend, that other vital functions in sheep, such as the respiratory, renal, hepatic, &c., so much resemble those of man, we can assume, I submit, without much risk, that if an animal can not live without a stomach neither can a man, hence the value of the experiment.

I am, Sir, yours truly,

CLEMENT H. SEES.

Queen's Road, Peckham, S.E., October 10th, 1901.

#### DIET IN RELATION TO THE CAUSE AND CURE OF CONSTIPATION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I have read with much interest Dr. Oldfield's communication upon the above subject in the number of your journal for October 2nd, 1901, page 352.

The wide prevalence of constipation, its importance as bearing on the health and well-being of the individual and the great difficulties of dealing with it without recourse to the routine employment of purgative and laxative drugs, must command attention to any communication or discussion which has a bearing upon it.

Personally—and I feel sure that I may speak for others as well as myself in the matter—I think that Dr. Oldfield would have greatly increased the interest and value of his communication, had he entered into

more details in connection with the special form of dietary he advocates.

The restrictions are clear enough; but when he says, "Give a fair proportion of milk and cereals, and give salads or conservatively cooked greens twice a day, and a mélange of fruit daily," to my mind the directions are too general; views might differ as to quantity and quality.

The questions arise:—

1. What does Dr. Oldfield hold to be a fair proportion of milk?
2. What cereals, and how cooked and served, does he give?
3. Of what does he compose his salads in the varying seasons of the year to secure an all-the-year-round supply?
4. What is meant by "conservatively cooked greens"?

I hope Dr. Oldfield may be induced to return to the subject, and to favour us with the benefit of his experience in providing for variety in the menus for the different meals.

I trust Dr. Oldfield will not for any moment think that these remarks are written in any carping spirit. I consider the subject one of the greatest importance, and we cannot have too much light thrown upon it; his paper is most suggestive, and must lead to further observations and experiments, with a view to solving the difficulties to be met with in this troublesome class of cases. Of the value of regularity as to time in soliciting an action of the bowels and of auto-abdominal massage, I can speak in the highest terms; both are most helpful in securing a free evacuation of the rectal contents.

I am, Sir, yours truly,

JOHN W. MARTIN.

#### THE CURE OF LEPROSY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Allow me to observe, regarding your editorial allusion to the questionable claim of Dr. Ehlers, that the Guber springs of Bosnia are curative in leprosy, that almost identical springs in Japan have been found not to be. Ehlers gives the composition of the Bosnian waters as arsenic, alum, iron, &c. The arsenic baths of Japan, according to a report on them in the "Transactions of the Asiatic Society" are about the same. Those Japanese baths have been appealed to by thousands of Japanese lepers for cure, but without avail, for hundreds of years. To-day, the Kusatsu hot springs are in higher favour, their remedial influence being greater. These last are distinguished by a very strong current of free mineral acids. In a full bath of 200 litres there are 440 grammes of free mineral acid, 280 grammes of sulphatic earths, 45 grammes of sulphatic iron. The baths, three to five a day, for a month or longer, are taken at a temperature of 45 to 50 C. But even these are not considered by Japanese leprologists as *curative*—only beneficial. The dry treatment of leprosy is preferred to the moist. Hot acupuncture, or dry air treatment, is much more efficacious, as has been proved in China since 2,000 years before Christ. It remains to be seen whether the hot American geysers and mud baths of our Yellowstone National Park, will prove beneficial in leprosy. I have already applied to the Government for samples of those waters and muds for analysis and experimentation. The Yellowstone Park—that is, one mile square in the centre of it (it is sixty miles square)—is the site proposed for our National Leper Home by the provisions of the Ashmead-Mulhane Leper Bill now before the American Congress.

I am, Sir, yours truly,

ALBERT S. ASHMEAD, M.D.

October 9th, 1901.

#### CANCER: ITS NATURE AND TREATMENT.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—As you so aptly remark, Dr. Webb's paper is full of interest and suggestive ideas, but the one thing needful is a microscopic examination of every case submitted to his treatment. One important point requires

further elucidation: Were the lymphatic glands affected in any of his cases, e.g., the case in which "the whole interior of the mouth and cheek was one mass of cancer"? To what extent? What was the effect of the treatment upon the glands?

Cholesterine is found in the bile and protoplasm of all cells—it is largely represented in nervous tissues and is found in blood corpuscles. The cause of crystallisation of cholesterine from the living cell may be organismal, the products of the organism acting chiefly upon the nervous system.

We should like also a further examination, microscopical and chemical, of the blood of the patient before and after the treatment.

Does the formation of gall stones in which cholesterine is largely present point to the presence of "uncontrolled cells" in the neighbourhood of the gall bladder or bile ducts?

Again, we should like to know more of the action of thyroid extract as an adjunct to the soap treatment. Is the whole process the result of a quarrel between Lecithin and cholesterine?

I am, Sir, yours truly,

S. J. ROSS.

"A LETHAL COIN."

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In your sensible comments in your last issue upon the death of a working man at the York County Hospital no mention is made of the application of the X-rays. Are we to conclude that the house-surgeon performed an operation with the object of searching for the coin upon such evidence as could be gathered from ordinary signs and symptoms? Was a Röntgen ray apparatus called into requisition, or did the York County Hospital fail to furnish the unfortunate patient with this most modern and marvellous aid to accurate surgical diagnosis? If that institution does not possess the proper apparatus the sooner its Committee take steps to procure a modern set and an expert medical radiographer, the better for everyone concerned. Medicine and surgery are progressive arts, and require the best and most modern appliance for their due exercise.

I am, Sir, yours truly,

RADIOGRAPHER.

London, W., October 17th, 1901.

Literature.

ROBSON AND MOYNIHAN ON DISEASES OF THE STOMACH (a).

THE name of Mayo Robson by itself is a tower of strength in connection with the surgery of the stomach; its power, moreover, cannot but be enhanced by the support received in this work from that of Mr. B. G. A. Moynihan, who has been so long and so honourably connected with the labours of the former eminent Leeds surgeon. It is most satisfactory to read in the preface: "We consider that we are justified in saying that our joint record shows that the risks of such surgery" (that of the stomach) "are far less than has been generally believed;" in the examples of operations given in the course of the book this dictum is amply verified. All surgeons will agree with the author's first sentence in speaking of diagnosis: "Although diseases of the stomach naturally come under notice of the physician at first, the time has passed when the surgeon can feel content to accept and act on the diagnosis already made for him by his medical colleague." Inspection, palpation, percussion, auscultation, instrumental aids, vomited matters, and contents of the stomach, exploratory incision are all ably considered and analysed in reference to their connection with the diagnosis of diseases of the stomach, a very pertinent remark in dealing with exploratory incision being: "When the tumour is exposed the great gift of knowing 'when to stop' comes in." Chapter I. is brought to a close with a very practical

(a) "Diseases of the Stomach and their Surgical Treatment." By A. W. Mayo Robson and B. G. A. Moynihan. Pp. 306 Baillière, Tindall, and Cox.

and interesting dissertation on gastrotomy. Congenital stenosis of the pylorus is the subject of Chapter II., and the reader is carried as far as possible into the pathology of that rather obscure condition. Injury of the stomach is lightly dealt with in Chapter III., and in Chapters IV., V., and VI. simple tumours, cancer, and sarcoma of the viscus constitute each an instructive study. The next six chapters comprise an exhaustive treatise on gastric ulcer and its complications, together with the various operations which may be undertaken for the relief of the patient. Chapter IX. on gastrorrhagia calls for special attention, and in a succeeding chapter perigastric abscess is dealt with in a masterly way; hour-glass stomach with its symptoms and treatment is then fully discussed, a large number of illustrative cases being given; the authors then pass on to the consideration of dilatation of the stomach, first as a complication of ulcer of the viscus, and secondly both as acute and atonic dilatation. In speaking of perigastritis, Chapter XIV., the authors lay great stress on the advantages of gastrolysis many illustrative cases being given. Gastric fistula and gastroptosis are lightly but satisfactorily dealt with in the next two chapters, and in the following as much light as possible is thrown on tuberculosis and syphilis of the stomach. With regard to the latter the authors very wisely say: "From a surgical point of view the subject is of great importance, since it would be easy to mistake a gummatous tumour of the stomach or pylorus for cancer, and perform gastrectomy when simple medical treatment would do all that is required

but while the question of syphilis is to be borne in mind it must not be forgotten that gummata of the stomach are extremely rare . . . and that too much time must not be lost in medical treatment in a doubtful case, lest the disease advance too far for surgical treatment to be of service." The chapter is completed by a few words on phlegmonous gastritis. The last chapter should form an object lesson for every surgeon, and constitutes a worthy ending to a work replete with interest. It comprises a description of the various operations in which the stomach is concerned; the mode of operating is given, together with the advantages and disadvantages of each. The book is well illustrated, and the type is excellent.

"FIRST-AID" DIAGRAMS. (a)

"INSTRUCTION in First-Aid" requirements is now so general throughout the kingdom that every assistance in the matter of illustration is sure to be appreciated. The provision of diagrams has always been a difficult question, for by no means every lecturer is possessed of the ability to give graphic expression to his ideas on a blackboard, and we have witnessed the most ludicrous failures in the attempt so to do. Hence we welcome the series of First-Aid Diagrams, advance proofs whereof have been submitted to us by Messrs. Wright and Co., of Bristol. The entire set comprises sixteen sheets, each sheet measuring (approximately) three feet by two. The total number of illustrations amounts to two hundred. Four sheets are devoted to anatomy and physiology, three to the use of the triangular bandage, and two to that of the roller bandage. Then we have two sheets allotted to the treatment of hæmorrhage and wounds, and two more to dislocations and fractures. The remaining three illustrate methods of artificial respiration and means of transport. It will be seen that the series covers the entire ground, and as the drawings are of a size to be readily visible to an average audience, they can be safely recommended to the notice of those who are interested in this branch of public education.

THE Committee of the North London Hospital for Consumption, Mount Vernon, Hampstead, has received a donation of £1,000 to name a bed "in memory of the late Mrs. Henry Claudet, who died at Cannes."

(a) "First-Aid" Diagrams for the Use of Lecturers." Bristol: John Wright and Co. Price (complete set), 27s. 6d.

## Medical News.

### Home Office and Pottery Manufacturers.

THE arbitration between the Home Office and the pottery manufacturers of Staffordshire as to the necessity for new rules in connection with the use of the lead glazes and the compulsory medical examination of the male operatives has been fixed for November 2nd, at Stoke-on-Trent. Lord James of Hereford will be the umpire. Professor Thorpe and Dr. Oliver, scientific experts, and Messrs. Sutton and Conynham, counsel, will appear for the Home Office. Mr. Fletcher Moulton and Mr. Brough will represent the manufacturers.

### A Herbalist's Defence.

A FEW days since a Limehouse herbalist, one John Purdue, was sued by the Society of Apothecaries in the Bow County Court to recover a penalty of £20 from him for practising as an apothecary without a certificate. For the defence it was urged that the Society was proceeding under one Act of Parliament, but his client was protected by another. He was a registered herbalist, and the Herbalist Act relieved him of any penalty. Counsel for the Society pointed out that that was an old Act of Henry VIII., which dealt with witches and sorcerers. The case was adjourned for the Acts to be examined.

### Barker Anatomical Prize.

THIS prize of twenty guineas, open to all medical students of the United Kingdom, has been awarded to Miss Susan Forster Dickson, a student of the Royal College of Surgeons in Ireland.

### St. Mary's Hospital Extension.

IT is announced that St. Mary's Hospital, Paddington, has at length succeeded in raising the sum of £25,000 required to secure the Zunz bequest of £25,000, and that the Clarence wing fund has now a potential balance of £50,000.

### West London Medico-Chirurgical Society.

THE opening meeting of the session was held on October 4th in the new building of the West London Hospital Post-Graduate College. Mr. Alfred Cooper, F.R.C.S., delivered the presidential address on "The Treatment of Inoperable Cancer," an abstract of which we publish elsewhere. A vote of thanks was proposed by Mr. Keetley and seconded by Dr. Ball. Mr. Swinford Edwards suggested that a special evening during the session might be devoted by the Society to the discussion of the interesting subject of the treatment of inoperable cancer. Mr. McAdam Eccles seconded the suggestion, and added that it might form an appropriate subject for the Society's discussion on February 4th, the subject for which he believed to be still unfixed. The President, in reply, stated that this suggestion would be considered by the Council at their next meeting.

### Remarkable Charge Against a Medical Officer.

AT the Kettering Police Court Dr. William Mackenzie, Medical Officer of Health for the Raunds District Council, was summoned for aiding and abetting a shoe operative unlawfully to expose himself when suffering from enteric fever at Raunds. It appeared from the evidence for the prosecution that two months ago an epidemic of enteric fever broke out in Raunds, which place was without provision for isolating and treating patients. Dr. Mackenzie sent one of the first patients to Kettering, which possesses an isolation hospital. The authorities there refused to admit him, whereupon he was taken to a house in Kettering and left there. The Kettering Council the next morning were obliged to take charge of him, and he was accordingly admitted into the hospital, where he remained until he recovered. A number of medical witnesses called for the defence stated that at the time the man was removed the fever had not reached the stage at which the patient could be a source of infection to others. The magistrates dismissed the case.

### Death under Chloroform.

THE Deputy-Coroner for Liverpool held an inquest last week relative to the death of Jane Jameson, aged 18. Chloroform and ether were used to produce anaesthesia for the purpose of an operation on the face. She recovered from the influence of the anaesthetic, but

about ten minutes later she vomited and ceased breathing. Medical evidence showed that death was occasioned by an enlarged gland pressing on the wind-pipe whilst straining in vomiting. The jury returned a verdict in accordance with the medical testimony.

AN inquest was held at the Brighton Throat and Ear Hospital, last week, on a man, æt. 39, who died while undergoing an operation for abscess of the ear. Artificial respiration was employed for two hours in vain. The usual verdict was returned.

A LABOURING man, aged 40, died under chloroform at the Royal Infirmary, Halifax, last week. An inquest was held, when "heart failure" was credited with having produced the fatal result.

### Proportions of Alcohol in Various Beverages.

MR. ALFRED H. ALLEN, Public Analyst for the West Riding of Yorkshire, gives the following figures as, roughly speaking, the proportions of alcohol (per cent. by volume) contained in various beverages, each kind of which is, however, liable to a certain range of strength:—

	Alcohol. Per cent.
<b>CIDER.</b>	
French, minimum of Pomological Society ...	4
" average of sweet samples ...	3.8 to 4.1
" " dry ...	5.4
" Paris municipal requirement average.	5 to 6
" " " minimum.	3
English—Bath and W. of England minimum.	4
" Norfolk, bottled ...	6 to 9
" Devonshire, bottled (extra dry) ...	6.7
" Herefordshire, bottled ...	6.6
American, dry ...	6.4
" sweet ...	2.5 to 4
<b>BEER.</b>	
Ordinary draught ..	4.5
Burton Pale Ale ...	6.3
Guinness's XX stout ...	6.6
Pilsen Lager ..	3.5
American Lager ...	2.8
<b>WINE.</b>	
Bordeaux (vin ordinaire) ...	7 to 9
Beaune ...	13
Rudesheimer ...	10
Champagne: ...	11 to 13

The proportion of proof spirit can be found by multiplying the figure for alcohol by seven and dividing the product by four, or, more accurately, by multiplying by 1.7515.

### Westminster Hospital Medical School.

THE following new entries—which we are glad to see in advance of recent years—have been made at this school:—Full curriculum, 17; partial entries, 27; dental studies, 1; University of London course, 7.

### Dublin Death-rate.

IN the Dublin registration area the deaths registered during the week ending October 12th, 1901, represent an annual death-rate of mortality of 20.3 in every 1,000 of the population. In fourteen cases the cause of death was uncertified, there being no medical attendant in the last illness; 53 children under five years of age died during the week. The great majority of these deaths were due to the filthy condition of the tenement houses of the city, the landlords of which appear callous not only to the comfort and health, but even to the lives of the poor who occupy their filthy houses.

### Royal College of Physicians of Ireland.

THE annual stated meeting of the Royal College of Physicians was held on Friday, October 18th, for the purpose of electing the officers of the College, the examiners, and balloting for candidates for Fellowships. William Arthur Winter, B.A., M.D. was elected a Fellow of the College; Sir Christopher J. Nixon was re-elected President, and Mr. J. M. Redmond Vice-President. The following elections were also made:—Censors: Dr. Redmond, Dr. O'Carroll, Dr. E. H. Tweedy, Dr. Langford Symes. Additional Examiners to take the place of an absent Censor—Medicine: Dr. Lennon; Medical Jurisprudence and Hygiene: Dr. S. T. Gordon; Midwifery: Dr

**Jellett. Examiners in Midwifery:** Dr. Glenn, Dr. Wilson. Examiners, in addition to Censors, under the Conjoint Scheme—**Biology:** Dr. Cosgrave; **Chemistry and Physics:** Dr. Bewley, Dr. Lapper; **Materia Medica and Pharmacy:** Dr. Falkiner, Dr. Drury; **Physiology:** Dr. Earl; **Pathology:** Dr. O'Sullivan; **Medicine:** Dr. Coleman, Dr. Peacocke; **Hygiene and Forensic Medicine:** Dr. Montgomery. **College Examiners for the Conjoint Preliminary Examination—Languages:** Mr. William Kennedy, F.T.C.D.; **Science:** Mr. W. E. Thrift, F.T.C.D. **Examiners for the Conjoint Diploma in Public Health—Meteorology:** Dr. Falkiner; **Hygiene:** Dr. Bewley; **Chemistry:** Dr. Lapper. **Representatives on the Committee of Management under the Conjoint Scheme—Dr. Finny, Sir J. W. Moore, Dr. Craig.** **Representative of the College on the General Medical Council—Dr. Atthill. Treasurer—Dr. Atthill. Registrar—Dr. Craig. Librarian—Mr. R. G. J. Phelps.**

A serious outbreak of typhoid fever is raging in the East Northumberland mining districts, many hundreds of cases being under treatment.

At Partick, N.B., upwards of five hundred persons have been attacked with grave diarrhoea and vomiting, consequent, it is believed, on the consumption of contaminated milk.

**Zymotic Disease in London.**

On Monday morning 175 patients suffering from small-pox were under treatment in the hospitals of the M.A.B. The daily increment of cases remain about the same. Of the 5,106 other patients, 3,287 are suffering from scarlet fever, 1,523 from diphtheria, and 274 from typhoid.

**The Bogus Doctor Committed.**

ABSOLAM W. HEAD, 53, who stands charged with manslaughter by gross and improper treatment, he having falsely represented himself to be a medical man, has been duly committed for trial.

**Victoria University Fellowships.**

VICTORIA University Fellowships in Medicine, of the value of £100 each, have been awarded to E. N. Cunliffe, M.B., Ch.B., Owens College, and G. W. Gelderd, M.B., Ch.B., University College, both of whom are undertaking research work in medical subjects during the coming year.

**Conjoint Examinations in Ireland by the Royal College of Physicians and Royal College of Surgeons.**

CANDIDATES have passed the Preliminary Examination as undernoted:—

Honours in order of Merit.—W. B. M. Orr, C. W. Greene, W. T. M. Browne, J. E. Hogan. (R. A. Barbour and A. C. Taylor, England.)

Pass, Alphabetically.—F. G. Allan, N. Allaun, D. Anderson, J. J. Besley, E. G. Carroll, L. Clifford, And. Cullen, E. M. Donovan, A. J. Faulkner, P. Foran, J. Gleeson, J. Halton, M. D. Healy, A. Hogan, G. M. Loughnan, J. Madden, T. N. Massey, W. S. L. Moorhead, C. M. Murphy, J. H. McCrear, Jas. O'Brien, T. T. O'Farrell, W. Ogilvy, H. Pentland, W. G. G. Quinn, W. H. Soady, M. Walters, P. I. Wigoder.

The following candidates have passed the First Professional Examination:—(a) In All Subjects.—M. J. Ahern, C. W. N. Anderson, J. B. Dwyer, G. H. Gallagher, and D. T. O'Flynn. (b) Complete the Examination: Miss H. O'D. M. Beamish, J. W. Bell, C. J. D. Bergin, E. J. Bonis, G. H. Caldwell, R. Calnan, P. M. Carroll, J. Daniel, O. S. Delany, M. J. C. Kennedy, G. H. Kinmouth, C. H. Lambert, B. Martin, P. Mullany, E. C. MacDermot, J. J. McNelis, J. O'Donnell, J. M. J. Rhathigan, F. J. Strahan, W. J. Tobin, N. E. Ussher, C. E. Wallace, and Thos. Young.

**The Royal University of Ireland.**

THE Examiners have recommended that the following candidates be adjudged to have passed the third examination in medicine:—

Upper Pass: \*Lily A. Baker, Cath. Univ. Sch. Med.; Daniel J. Boyle, Cath. Univ. Sch. Med.; \*Patrick Dwyer, Cath. Univ. Sch. Med.; Michael F. Farrell, Cath. Univ. Sch. Med.; \*Daniel Gillespie, Queen's Col., Belf.; James M. A. Holmes, Queen's Col., Belf.; \*Thomas Lyle, Queen's Col., Belf.; \*Joseph O.

McPherson, Queen's Col., Belf.; \*James N. Moenan, Cath. Univ. Sch. Med.; \*James H. Moore, Queen's Col., Belf.

Those marked with an asterisk may present themselves for the further examination for honours.

Pass: Arthur P. Barry, Cath. Univ., Sch. Med.; Christopher Baylor, Queen's Col., Cork; Charles J. Boucher, Queen's Col., Belf.; Michael Cagney, Queen's Col., Cork; James Campbell, Queen's Col., Belf.; Perwin T. Crymble, Queen's Col., Belf.; Lillie E. Dunn, Queen's Col., Belf.; Maurice FitzGerald, Cath. Univ. Sch. Med.; Dudley Forde, Queen's Col., Gal.; Marie E. Hayes, Cath. Univ. Sch. Med.; Jacob I. Jaffé, Queen's Col., Cork; Edward B. Kenny, Cath. Univ. Sch. Med.; Charles G. Lowry, Queen's Col., Belf.; James F. McDermott, Queen's Col., Cork; Daniel McGrath, Queen's Col., Belf.; Joseph C. MacHugh, Cath. Univ. Sch. Med.; Richard G. Meredith, Cath. Univ. Sch. Med.; William Minford, B.A., Queen's Col., Belf.; John W. Pitt, Queen's Col., Belf.; Jane E. Reynolds, Queen's Col., Cork; Daniel J. Roantree, Cath. Univ. Sch. Med.; Francis C. Sampson, Cath. Univ. Sch. Med.; Mary E. Simms, Queen's Col., Belf.; William A. Simpson, Queen's Col., Gal.; John Thompson, Queen's Col., Belf.; Cecil B. F. Tivy, Queen's Col., Cork; David H. Vickery, Cath. Univ. Sch. Med.; Thomas Walsh, B.A., Queen's Col., Gal.; James E. Wilson, Queen's Col., Belf.

**Royal College of Surgeons in Ireland.**

THE following candidates, having passed the necessary examination, have been admitted Fellows of the College: Mr. J. M. Falkiner (Assam, India), Mr. G. A. Gunton (London), Mr. W. H. Langley (Nigeria, W. Africa), Mr. J. R. Macnamara (Assam, India).

**Royal College of Surgeons, Edinburgh.**

At the annual meeting, on the 16th inst., Dr. John Halliday Croom was elected President for the ensuing year. "The Victoria Jubilee Liston Prize" of £100, founded by His Excellency the late Dr. Robert Halliday Gunning, of Rio de Janeiro and Edinburgh, for the greatest benefit done to practical surgery by any Fellow or Licentiate of the College during the quadrennial period ending June 20th, 1901, was awarded to Francis Mitchell Caird, F.R.C.S. Edin., Edinburgh.

The Surgical Essay Prize of 100 guineas offered by the College for an original unpublished essay on surgery in any of its branches, on anatomy, physiology, therapeutics, or pathology, in their relations to surgery, was awarded to James Veitch Paterson, F.R.C.S. Edin., the title of whose essay was "The Lymph Flow through the Eyeball."

The following gentlemen, having passed the requisite examinations, were admitted Fellows of the College: Francis Cubbon Rogers, L.R.C.S.E., James Adam Dick, M.D., Clement Somerton Clark, M.B., Ch.B., Edwin Zerubabel Davis, M.B., L.R.C.S.E., William Henry de Silva, M.B., C.M., John Robert Foster, M.B., C.M., Andrew Gibson, M.B., Ch.B., Sampson John Rodger Greville, L.R.C.S.E., David Heron, L.R.C.S.E., William Llewelyn Jones, M.D., John Stuart Shepherd Lumsden, M.B., C.M., William John Orr, M.B., C.M., Ernest John Peill, M.B., Ch.B., Bertram Crossfield Stevens, M.D., M.R.C.S. Eng., and William Young, M.D.

**Society of Apothecaries of London.**

THE following candidates passed in:—

**Surgery.**—C. E. C. Child (Section II.), G. B. Dixon (Sections I. and II.), P. J. FitzGerald, I. Griffith (Section I.), W. B. Harris (Section I.), D. Morrow (Sections I. and II.), W. Parker (Section I.).

**Medicine.**—D. E. Lockwood (Section II.), E. E. Naggjar (Sections I. and II.), W. Parker (Sections I. and II.), F. M. Payne (Section II.).

**Forensic Medicine.**—E. C. Curtis, R. Gillett, E. E. Naggjar.

**Midwifery.**—T. J. M. Clapperton, A. F. Heald, P. S. Hopkins, H. Johnson, G. F. G. De Laubenque, T. G. Miles, W. Parker, H. Richardson, C. W. Smith, A. Turner.

The diploma of the Society was granted to the following candidates, entitling them to practise medicine, surgery, and midwifery:—C. E. C. Child, G. B. Dixon, P. J. FitzGerald, D. Morrow, E. E. Naggjar, and H. Richardson.

## Notices to Correspondents, Short Letters, &c.

**CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *distinctive signature* or initials, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

ORIGINAL ARTICLES or LETTERS intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication, but as evidence of identity.

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the publisher or printer before the type has been distributed. This should be done when returning corrected proofs.

OUR AUSTRIAN CORRESPONDENT'S weekly letter was received too late for insertion in our present number owing to a postal irregularity.

DR. F. N.—Your communication reached us just as we were going to press, and we were unable to make use of it. Circumstances have since undergone such further development that your object may be regarded as attained.

DR. W. A. P.—We shall not be able to avail ourselves of the M.S. unless it reaches us by Friday next.

VELOX.—It is by no means a bad thing for a man, busy though he be, to have a "fad" to occupy his attention outside his business hours, even though that fad takes a statistical form, prompting him to compute highly imaginary quantities. One of these irrepressible statisticians amused himself by calculating the amount of coal suspended over London in the form of smoke, which he put at the fabulous amount of three (or thirty) thousand tons, we are not sure which. Another (possibly the same) estimated that Glasgow saved £36,000 a year in soap since a supply of soft water has been rendered available. So long as these figures are not taken too seriously no harm is done, and sometimes, by exciting hostile criticism, useful information is gained thereby.

### ALABONE AND HIS PRETENSIONS.

MR. ALABONE has not thought fit to avail himself of our offer to make known the details of his much-vaunted treatment, nor has he given a favourable consideration to our suggestion to have it tried at the Brompton Hospital. This latter fact is the subject of a letter to *The Times* by Dr. J. E. Pollock, who suggests that Alabone should "hang up his banner alongside the pill merchants," as he declines to submit his pretensions to scientific control. The curious thing is that a journal of the standing of *The Times* should have allowed its columns to be taken advantage of to advertise an egregious quack.

VERAX.—We cannot tolerate personalities of the virulent type contained in your communication, especially under a pseudonym, although we should hesitate to give them publicity even if you were willing to append your signature.

### A HANDBOOK ON SMALL-POX.

MISS FLORENCE WHITE has just published a little volume on small-pox, which is intended to serve as a guide to its recognition and treatment. There is a chapter on vaccination, in which its value is impartially discussed. Such a work cannot but prove useful at the present juncture, and as it only costs sixpence, it should find its way into the households of those who are likely to profit by the information it contains.

## Meetings of the Societies.

WEDNESDAY, OCT. 23RD.

DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND (20, Hanover Square, W.).—4.30 p.m. Informal Exhibition of Cases.—5 p.m. Meeting.

HUNTERIAN SOCIETY (London Institution, Finsbury Circus, E.C.).—8.30 p.m. Clinical Evening.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chancery Street, W.C.).—4 p.m. Mr. Hutchinson; Clinique. (Surgical.) LONDON THROAT HOSPITAL (204, Great Portland Street, W.).—5 p.m. Dr. Stoker: Chronic Glandular Diseases of Naso-Pharynx. (Post-Graduate Course.)

FRIDAY, OCT. 25TH.

CLINICAL SOCIETY OF LONDON (20, Hanover Square, W.).—8 p.m. Exhibition of Clinical Cases followed by Discussion. Patients will be in attendance from 8 p.m. to 9 p.m.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chancery Street, W.C.).—4 p.m. Dr. St. Clair Thomson: Clinique. (Throat.)

FRIDAY, NOV. 1ST.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.—8.30 p.m. Ordinary meeting in the Society's rooms, West London Hospital.

## Appointments.

BONNEY, W. F. VICTOR, M.D., M.S. Lond., F.R.C.S. Eng., M.B.C.P., Physician Accoucheur to the St. Pancras and Northern Dispensary.

DAVIS, HARRY, M.B.C.S., L.R.C.P., L.S.A., D.P.H. Cantab., Medical Officer of Health for Collington, Cornwall.

HODGSON, J. F., M.B., Ch.B. Vict., Resident Medical Officer of the Halifax Union Poor-law Hospital.  
MATHESON, RODERICK M., M.D., M.S. Edin., Honorary Assistant Surgeon to Noble's Isle of Man Hospital.  
PARSONS, JOHN HERBERT, M.B., B.S., B.Sc. Lond., F.R.C.S., Curator and Librarian to the Royal London Ophthalmic Hospital.  
PEGGE, EDWARD VERTON, L.R.C.P. Lond., M.B.C.S., Medical Officer of Health for Brisson Ferry, Glamorganshire.  
RODGERS, E. CRAIG, M.B.C.S., L.R.C.P. Lond., Honorary Medical Officer to the Burnley Victoria Hospital, vice Dr. James Mackenzie, resigned.  
WHITE, MAURICE FORBES, M.B., Ch.B. Aberd., Resident Surgeon to the Birmingham General Dispensary.

## Vacancies.

Birmingham City Asylum.—Junior Assistant Medical Officer, unmarried. Salary £150 a year, with board, apartments, and washing.  
Birmingham General Dispensary.—Resident Surgeon, unmarried. Salary £150 per annum, with rooms, fire, lights, and attendance.  
Bristol General Hospital.—Assistant House Surgeon. Salary £70 per annum, with board, residence, &c. Applications to the Secretary.  
Chelsea Hospital for Women, Fulham Road, S.W.—Registrar. Honorarium, 20 guineas per annum.  
Cornwall County Asylum, Bodmin.—Junior Assistant Medical Officer, unmarried. Salary £120, rising to £150, with board, apartments, laundry, &c.  
Derby County Asylum, Mickleover.—Junior Assistant Medical Officer. Salary £110, rising to £130 per annum, with apartments, board, washing, and attendance.  
Dublin, Trinity College.—King's Professorship of the Institute of Medicine (Physiology and Histology) in the School of Physic.  
Essex County Asylum, Brentwood.—Junior Assistant Medical Officer. Salary £140 per annum. Apply to the Medical Superintendent.  
Glasgow University.—Additional Examinerships in Medicine and Science, with special reference to Chemistry, Materia Medica, Zoology, Practice of Medicine and Surgery. Particulars as to dates, emolument, &c., on reference to our advertising columns.  
Hospital for Consumption and Diseases of the Chest, Brompton.—Resident Medical Officer. Salary £200 per annum, with board and residence.  
Hospital for Sick Children, Great Ormond Street, London, W.C.—House Surgeon, unmarried, for six months. Salary £20, washing allowance £2 10s., with board and residence; also Surgeon Dentist.  
Ingham Infirmary.—Senior House Surgeon wanted. Salary £100 per annum, with residence, board, and washing. Applications to the Secretary, 74, King Street, South Shields.  
Morpeth Dispensary.—House Surgeon, unmarried. Salary £120 per annum, with rooms, coals, gas, and attendance.  
Plymouth Borough Asylum.—Assistant Medical Officer, unmarried. Salary £150 per annum, rising to £200, with apartments, board, and washing.  
Pretoria Civil Hospital, Transvaal.—Resident Assistant Medical Officer for three years, unmarried. Salary £300, £350, and £400, with board, lodging, and washing. Allowance of £50 on arrival in Pretoria for travelling expenses.  
Royal National Hospital for Consumption and Diseases of the Chest, Ventnor.—Resident Medical Officer, unmarried. Salary £150 per annum, with board and lodging.  
Royal Victoria Hospital, Belfast.—Medical Superintendent. Salary £300 per annum, with board and apartments.  
York County Hospital.—House Surgeon. Salary £100 per annum, with board, residence and washing.  
York Dispensary.—Resident Medical Officer, unmarried. Salary £110 a year, with board, lodging, and attendance.

## Births.

COLLCUTT.—On Oct. 14th, at 2, St. Peter's Place, Brighton, the wife of Arthur M. Colcutt, M.B., of a daughter.  
PERSHORE.—On Oct. 13th, at Chipchase, Hadley Wood, the wife of Frank Pershore, M.B.C.S., L.R.C.P. Lond., of a son.  
RAY.—On Oct. 11th, at 48, The Crescent, Salford, the wife of John Howson Ray, Ch.M., F.R.C.S., of a son.

## Marriages.

BROWN—PULLEN.—On Oct. 16th, at St. Helen's Church, Abingdon, Berks, by the Rev. M. T. Maitland, M.A., Thomas Henry Brown, M.A., M.B., B.C. Camb., of Hampden-in-Arden, Warwickshire, to Isabel Mary, eldest daughter of Richard Pullen.  
GILLESPIE—KEDDIE.—On Oct. 17th, at the Windsor Hotel Glasgow, by the Very Rev. John Fagan, D.D., S.A. D. Gillespie, M.B., C.M. Ed., of Dalbeattie, to Mary Sybilla, eldest daughter of D. B. Keddie, of Kelvinside, Glasgow.  
HAMCOCK—LEUCHARS.—On Oct. 15th, at the parish church, Isleworth, by the Rev. J. H. Champion McGill, George Charles Hamcock, M.B.C.S., L.R.C.P., D.P.H. Lond., St. Margaret's, Twickenham, to Effie, only daughter of John Walter Leuchars, of The Chestnuts, St. Margaret's, Twickenham, and of Darban, Natal.

## Deaths.

BENTHAM.—On Oct. 15th, at Ellerslie, Willeeden, Robert Bentham, M.D., aged 81 years.  
DALELL.—On Sept. 21st, at the Gordon Memorial Mission, South Africa, Rev. James Dalell, B.D., M.B., C.M., medical missionary, aged 60.  
LIVINGSTONE.—On Oct. 4th, at 17, Hill Street, Wishaw, Lanarkshire, James Livingstone, M.D., L.R.C.S.E., J.F., aged 67 years.



# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXIII.

WEDNESDAY, OCTOBER 30, 1901.

No. 18.

## Paris Clinical Lectures.

### THE TREATMENT OF GASTRIC ULCER.

By Dr. ROBIN,

Professor of Medicine at the Faculty of Medicine of Paris.

FOR many years Cruveilhier's classical work was the basis of the rational treatment of gastric ulcer; but recent views on the causation of this lesion have raised doubts in the minds of many experienced practitioners as to the value of purely medical treatment. Later on, surgeons, who at first only intervened in the event of complications such as perforation and hæmorrhage, began to consider themselves justified in proposing the radical cure of gastric ulcer. This operation is certainly called for in certain exceptional cases, but as a general rule the ulcer is perfectly amenable to medical treatment.

Let us consider first of all the pathological anatomy of gastric ulcer. The ulcer is invariably situated in one or other of certain special points to the exclusion of the rest of the organ, viz., the prepyloric region, the lesser curvature, and the posterior wall, especially in the inferior third of the stomach, that is to say, the area where the food sojourns during digestion. The ulcer is generally single, although according to Brinton more than one ulcer is met with about once in every sixty cases. In my hospital experience, however, during the last ten years, in which 200 autopsies were made, I have never once met with a double ulcer. The ulcer is generally round, sometimes oval, and varies in dimensions between a sixpenny-bit and a crown. The edges are clean cut as by a knife; the erosion has the form of a truncated cone, invading successively the mucous membrane, the sub-mucous, muscular and cellular coats; the last named is formed by the serous membrane, or, if perforation exists, by a neighbouring adherent organ. The ulcer heals by the production of cicatricial tissue devoid of glands. It is extremely liable to recurrence.

Simple ulcer of the stomach appears to end in recovery in 90 per cent. of the cases. When of small dimensions the cicatrix does not cause much inconvenience, but when it affects a semilunar form occupying the small curve and invading the posterior and anterior walls the contraction of the cicatrix is sometimes so marked, that the stomach may be divided into two compartments and has an hour-glass shape, to which the name of "gastric binoculation" has been given.

When the ulcer is situated in one of the folds of the pylorus it provokes painful contractions, stenosis is the result with the immediate consequence of stasis of the contents of the stomach with consequent prolonged contact of the gastric juice, which has for result the further progress of the erosion.

This condition is comparatively rare (1 to 3 per cent. of the cases). The treatment of this form lies in surgical intervention, which alone can afford relief.

Let us pass now to the pathological histology. A certain number of facts are now well-established, but we are not agreed as to their significance. The most important question is, however, easy enough to solve if we investigate the condition not only in the neighbourhood of the ulcer, but over the entire surface of the organ. It is generally admitted that the ulcer is always associated with a pathological condition of the mucous membrane as a whole. The lesions of hyperpeptic gastritis are found (Hayem) as well as those of chronic gastritis. In a word, all possible varieties of acute and chronic gastritis are present. It is evident that these lesions are anterior to the formation of the ulcer. It is the chronic form which is first in date, and it exists in every case of simple ulcer.

Let us now discuss the ætiology as bearing on the therapeutical indications. Simple ulcer of the stomach is, by no means, a rare affection. It is met with, on an average, once in every 100 autopsies. Females are more frequently affected than males in the proportion of 1½ to 1; its maximum frequency is between 30 to 40 years of age for man and 20 to 35 for woman. In respect of causation, the influence of certain climates and certain callings, such as cooks, polishers, &c., have been incriminated, but as a matter of fact they go for little. The malady may attack indifferently individuals belonging to every class of society. The only cause which by its constancy appears to possess a real value is hypersthenic and acid gastritis. It may safely be affirmed that there does not exist a single case of simple ulcer which has not been preceded by a period of dyspepsia and gastritis. There are two constant and well-established facts: one of clinical chemistry, viz., the presence of an excess of hydrochloric acid in the gastric juice; the other, anatomopathological the existence of chronic gastric lesions in various stages of development. I need only briefly refer to some of the numerous theories advanced by authors to explain the production of ulcer, as none of them absolutely fit in with the clinical facts: the vascular theory (Hirschell) admitted by many; thrombosis and embolism (Godinier); venous stasis (Rokitansky); hæmorrhagic infarction (Rindfleisch); and, lastly, the infective theory, which, although accepted by many, is not admitted by the majority of specialists.

The onset of simple ulcer of the stomach is generally as follows: a man suffers from his stomach for a very long time (dyspepsia), he eats with a good appetite and digests tolerably well, but, curiously enough, he loses flesh and has a cachectic appearance. Immediately after meals the patient experiences a sensation of comfort, but in the course of from three to five hours he is seized with pain in the region of the

stomach. Sooner or later the scene changes, the patient begins to suffer immediately the food comes in contact with the mucous membrane of the stomach, whereas previously, there was an interval of comfort of three or four hours after eating. Consequently when you find the ingestion of food provoking immediate pain in a patient with a history given as above you may begin to think seriously of ulcer. Pain on eating is one of its first manifestations. The dyspeptic symptoms become aggravated, the general health is affected, and the patient begins to vomit, at first food, and ultimately blood. Such may be regarded in a general way as the course of gastric ulcer. The fundamental symptoms which make up the clinical picture of ulcer are consequently three in number: pain, vomiting, and hæmorrhage. We will pass them successively in review.

*Pain.*—I have just told you that its most important feature is its being provoked by the ingestion of food. But people attacked with ulcer suffer all the time, they are never one hour free from pain, more or less. Certain foods provoke this pain much more than others. All solids, for instance, acids, sometimes pastry, or fatty matter, this, however, varies with almost every patient.

The second symptom is *vomiting*, which generally comes on three or four hours after the repast. It is exceedingly acid, irritates the throat, puts the teeth on edge, and the patients say that it has the taste of vinegar. Vomiting, however, is not invariably present, but its absence is exceptional.

The third symptom is *hæmorrhage*. This may be observed in three forms: grave hæmorrhage, moderate hæmorrhage, and slight hæmorrhage. In the first form the patient is seized suddenly with a very distressing sensation in the epigastrium, turns pale and appears to be about to faint, then he vomits a very large quantity of blood. This hæmorrhage may prove immediately fatal, but according to the statistics of Salomon, of New York, this termination is only observed in three or four per cent. of the cases. Moderate hæmorrhage, which is always of grave significance, is never fatal unless repeated frequently. The patient experiences an uneasy sensation at the pit of the stomach, turns pale, has vertigo, hiccough, and suddenly vomits blood. In certain cases the patient retains the blood in his stomach, which, after digestion, is eliminated by the intestine. Consequently, whenever you see a patient suffering from ulcer, but in whom hæmatemesis is absent, turning suddenly pale and presenting the aspect of acute anemia, do not forget to ask him if his stools are black; he will generally answer in the affirmative.

When you have examined the four orders of phenomena—pain, vomiting, hæmorrhage, and dyspepsia—you must next look for the physical signs. These are very important.

We will now endeavour to apply to the treatment the various details mentioned above. You may have asked yourselves why I chose this subject since there exists the well-known classical treatment which Cruveilhier instituted for the first time in 1830, and which since then has been in daily use. It has indeed become so generally employed that it is almost impossible to-day to separate the idea of milk diet from ulcer of the stomach. It must be admitted that a method which during seventy years has resisted every attack and received the support of several generations of medical practitioners necessarily possesses a real and indisputable value. Therefore, like all my *confrères*, I approve of it, employ it, and inculcate it. But from extensive experience I have arrived at the conclusion that it is advantageous to precede the milk *regime* by a preliminary and preparatory treatment not comprised

in the original method. That is a point which renders this treatment worthy of our attention. I shall also have to discuss with you the use of certain remedies which have been proposed during the last few years as substitutes for milk diet. Lastly, I shall have to discuss the important question now quite the order of the day, that of surgical intervention in ulcer of the stomach.

Here, in a word, is the treatment actually employed. The fundamental indications on which it rests are four in number.

(a) *Prophylaxis.* We know to-day that simple ulcer is consequent upon hypersthenic gastritis, with excess of hydrochloric acid.

(b) When you meet with a case of simple ulcer, in which the diagnosis is clear, the first indication is to give the stomach absolute rest, in order to allow the healing of the ulcer on the one hand, and to diminish, on the other, all excitement which might provoke the secretion of gastric juice (HCl). Rest of the stomach is consequently an essential factor, but at the same time the patient must be nourished sufficiently by appropriate means.

(c) *Treatment of secondary symptoms.*

(d) *Relief of the numerous complications which appear in the course of the affection.*

The first indication, as I have said, is functional rest. Formerly the milk treatment was commenced immediately the existence of gastric ulcer was recognised. Well, the experience I have acquired in the treatment of the malady, and the results obtained by Fournier and Gros, of Lyons, during the last few years, have proved the necessity of putting the patients through a preparatory treatment, consisting in absolute rest, before putting them on a milk diet. The following is the treatment I adopt to fulfil this indication:—The patient is kept in bed; a towel steeped in hot water and covered with oiled silk and cotton wool is placed over the epigastrium, and kept in position by means of a flannel bandage; no nourishment is given by the mouth, not even milk or water. Each day the patient is given four enemata composed of two eggs beaten up with two spoonfuls of peptone, thirty grains of salt, a few drops of laudanum, and three ounces of glucose (20 per cent.). The whole enema should measure about six fluid ounces. Two other enemata of simple warm water are given during the day to supply the organism with the necessary amount of liquid.

To accustom the patients to this treatment it is well to increase the number of enemata gradually until complete tolerance is obtained. Where intolerance is present (which happens in about one of every fifteen cases according to my own experience), we must endeavour to overcome it by increasing the laudanum to twelve or fifteen drops, or by suppressing the salt and the peptone, which seem to be the substances which usually provoke the intolerance.

According to MM. Fournier and Gros the treatment should be continued for a fortnight, and in some cases for a month, but personally I have never found it necessary in my own cases to prolong the period of functional rest beyond twelve days at the outside, and frequently only for three or four days. The signs by which we may know that the rest cure should be abandoned, are the following:—Persistent rectal intolerance, progressive enfeeblement of the patient, and when, in spite of the treatment, the cardinal symptoms of the ulcer, which I have already mentioned, persist.

I need only mention *en passant* the alternative for the rectal method of introducing food, viz., the subcutaneous method, a suggestion which gave rise to a highly instructive debate at the recent Congress held in Paris, and the conclusions arrived at were that

the subcutaneous method was not practicable and frequently gave rise to untoward symptoms. Personally, judging from two or three trials I have given this method, the results were not such as to encourage me to advise you to adopt it.

Let us now discuss what takes place under the influence of the rest cure. In the majority of cases the symptoms are appeased, the gastric pain and the epigastric tenderness disappear, and the loss of weight is checked.

The rest cure having come to an end, the patient should be put on a milk diet, gradually increasing the daily amount until we have reached four quarts. This régime should be continued not less than six months. At the expiration of this period a mixed diet may be ordered for a fortnight, consisting of milk foods prepared with tapioca, arrowroot, rice, &c., and a few vegetables. After this period of transition the milk is suppressed and meat and fish ordered, as well as eggs, vegetables, and cooked fruit.

Such are the fundamental indications of what I call the methodical treatment of simple gastric ulcer. The treatment covers seven or eight months. In the majority of cases the patients are completely cured, they suffer no more from the stomach, their general condition is excellent, and, in fact, better than before the malady. There are, however, a certain proportion of patients, five out of twenty, who will require a complementary treatment. These patients may be divided into two distinct categories; those who present a certain degree of nervous depression bordering on neurasthenia, and patients in whom signs of anæmia predominate. The treatment of these two groups of patients is quite different. For those who suffer from anæmia the best medicine is certainly iron, and the best preparation is perchloride of iron administered in pills of two grains, taken at meal times. The neurasthenic patients should be treated with preparations of arsenic. I used to prescribe with success intra-rectal injections of arsenic, but since Gautier's discovery of cacodylate of soda I employ this preparation in subcutaneous injections in doses of one grain daily for eight consecutive days, followed by an equal number of days of repose, and continued during forty days. The cacodylate of soda gives remarkable and ever unhopèd-for results, in the gravest cases accompanied by cachexia, and by its employment surgical intervention can sometimes be obviated.

We will now briefly review certain methods of treatment recently proposed as a substitute to the method of Cruveilhier. The first method is that recommended by Fleiner, and it is highly thought of in Germany. It consists in the administration of sub-nitrate of bismuth in the following way: a suitable quantity of this substance is introduced into the stomach by means of a tube, and left in contact with the stomach for a certain time, the position of the patient being changed from time to time so as to ensure the contact of the bismuth with the gastric ulcer, after which the bismuth is syphoned off. The quantity of the powder employed by the parti-

sans of this method is sometimes enormous; the most moderate employ six drachms, while others, Herschill, for instance, use six or seven ounces. I am unable to recommend this treatment on account of the risk to which the patients are exposed by the introduction of a tube into the stomach. We may dismiss in a word or two the practice of washing out the stomach with a solution of nitrate of silver (Boards), with perchloride of iron (Bourget, of Lausanne), methods which cannot be recommended for the same reason.

The employment of bicarbonate of soda in large doses has been proposed. Here no instrument is required and the principle seems rational. From two drachms to two ounces of bicarbonate of soda are ingested daily. This method is also illusory, because, as was proved by Claude Bernard, alkalies excite the secretion of hydrochloric acid. I am therefore opposed to the employment of bicarbonate of soda in the treatment of simple gastric ulcer.

I have still two other points to deal with before terminating this study: The treatment of predominating symptoms, pain, vomiting, constipation, or diarrhoea on the one hand, and that of complications of simple ulcer, with special regard to hæmatemesis on the other. These will be the subject of a future lecture.

### SOME UNUSUAL GYNÆCOLOGICAL CASES. (a)

By H. MACNAUGHTON-JONES, M.D.,  
M.Ch.R.U.I., F.R.C.S.Irel.

THE tumour (fig. 1) which I show was removed from a young lady, æt. 22. She had been married for two years and a half at the time of operation, and had completed her first pregnancy at the end of the first year of her married life. She was brought to me by Dr. Disney in January, 1901, and complained of con-

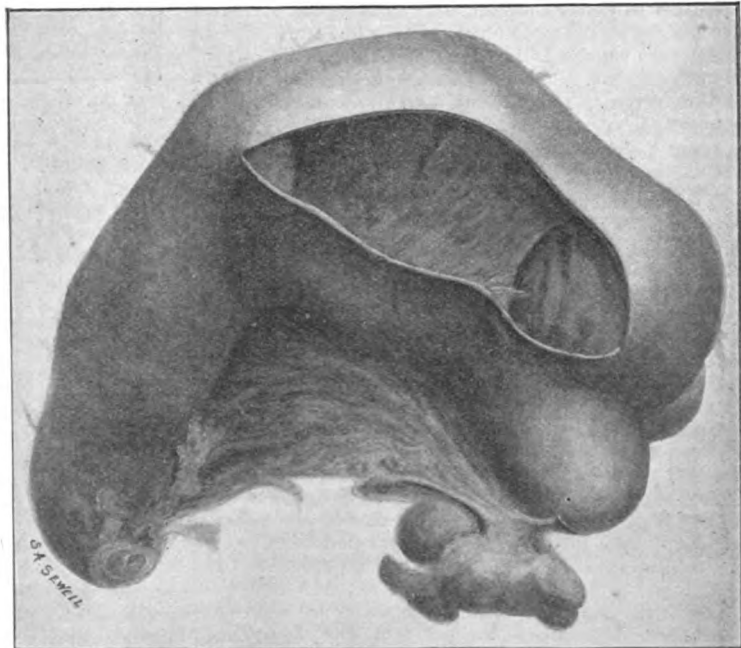


FIG. 1.—Primary tuberculous pyo-salpinx. (Sac opened.)

siderable and constant pain in the left side, with inability to walk and dyspareunia. The catamenia had been regular and normal. On examination I found the adnexa on the left side much enlarged, softened, and very sensitive. The right were not enlarged, but I could distinctly feel adhesions. I advised immediate operation, either exploration by colpotomy or abdominal celiotomy, the affected adnexa to be dealt with either by removal or resection, according to circumstances. This was practically agreed to, but, by the advice of a distinguished obstetric physician who saw her immediately after I did, operation was declined, and who expressed the hope that by rest and a course at Woodhall Spa none would be required.

I did not see the patient again until July 10th, 1901. I operated on her the next day. Pain had then been for some time agonising, and she herself demanded operation. The condition of the right adnexa can be judged from the specimen (fig. 1). The Fallopian tube was distended with pus, forming a long crescentic swelling an inch and a half in diameter at its widest part, the surface of the tube being adherent. The right ovary, though fixed by some adhesions, was healthy. A large perimetric cystoma had formed behind the meso-salpinx, between the distended tube, the ovary, and the adjacent viscera. Mr. Targett examined the specimen for me. The following is the conclusion of his report:—

“The external surface of the specimen is covered with thin fibrous adhesions in which many miliary tubercles are embedded. The lumen of the tube is filled with thick caseous pus, and the inner surface is shaggy from ulceration of the mucous membrane. There is very little thickening of the wall of the tube anywhere, and in some parts it is much thinned by distension and ulceration. Microscopical sections of the undilated uterine end of the tube exhibit general thickening of the mucous membrane and infiltration with miliary tubercles. The epithelial lining is for the most part intact.”

This is the second case I have had of primary tuberculosis of the Fallopian tube in a young woman otherwise in perfect health, and without any hereditary history of tuberculous disease. The first, which I elsewhere reported in full (a), was complicated with hæmato-salpinx. The particulars of this case speak for themselves. The patient made an uninterrupted recovery.

#### CASE OF LARGE HEENIA FOLLOWING CÆLIOTOMY.— OPERATION.

This was the largest post-operative hernia I have ever seen. The drawing, which was taken from a photograph, gives a fairly good idea of its extent. When I saw the patient in May of the present year the bowel was down in a large sac, which protruded over the pubes, covered only by the integument (fig. 2). A large space of several inches separated the recti muscles and fascia. The bowel appeared to be adherent in parts to the parietal covering. She had been subject to recurrent attacks of severe pain due to attacks of sub-acute peritonitis, and had to be confined to bed for several weeks before operation. The old cicatrix extended from a short distance below the umbilicus to about two inches above the pubes. I did not learn until the day of the operation (Sept. 2nd, 1891) that the patient had been twice operated upon and that on the second occasion the abdominal wound had been closed without sutures, the parts having been brought together by adhesive plaster. I determined to perform the following operation:—

The steps may be understood by the accompanying diagram (fig. 3). Having carefully incised the skin

(c c) in the middle line over the cicatrix, by a cautious dissection vertical to the bowel, which was immediately subjacent and in parts adherent, it was reflected back to the extent of some three inches at either side (c<sup>1</sup>). Some dense fascia (b) was then exposed, continuous with the peritoneum and the fascia of the rectus (a a). This fascia also was raised and reflected back, the dissection including a portion of the rectus sheath fascia. All bleeding points from adhesions of the bowel were secured. The omentum and bowel were covered with a sterilised napkin wrung out of warm formalin solution, and mattress sutures were then carried from side to side in the following manner:—Two straight ovariectomy needles, each threaded with fairly strong silver wire, were passed from before backwards through the inner border of the rectus including the fascia, across the space intervening between the recti, and then passing under the dissected fascia, were brought out at corresponding points on the opposite side. Six of these were carried alternately in the manner shown in the drawing, and a single strong wire was passed at the upper and

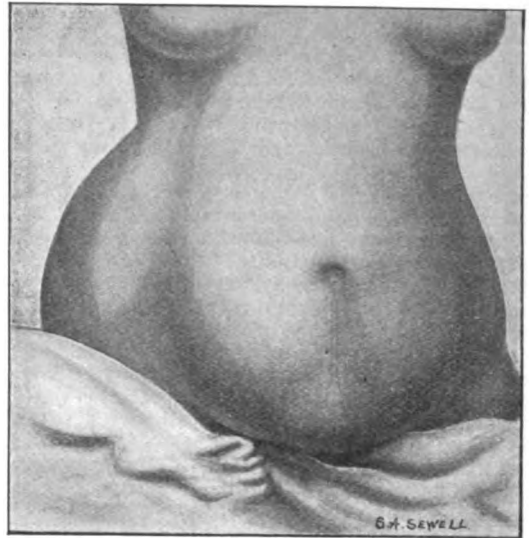


FIG. 2.—Before operation. (From photograph.)

lower angles of the wound. The central sutures were separated, and the napkin readily withdrawn between them. They were then tightened, and the ends, twisted and cut close, were buried in the rectus muscle. This brought into apposition the rectal fascia of either side with the muscle and the underlying peritoneum, leaving a raised flap of fascia which projected for the entire length of the incision. This was paired, made to overlap, and then closed with silkworm gut sutures, which were cut short. The skin margins were then united. There was no trouble whatever after the operation, which the patient bore remarkably well, and she has since left this country on a long voyage.

#### • VERY LARGE FIBROMYOMA—HYSTERECTOMY— RECOVERY.

The patient from whom this tumour was removed was a multipara, æt. 50. Her last pregnancy was in 1890. She had never suffered any particular pain, and cannot date the commencement of the growth. She noticed an enlargement some two years since, but only within the last few months had there been a rapid increase in size. The catamenia had been irregular in occurrence and quantity, and there was considerable loss a few days before operation.

On examination, a large movable semi-solid abdominal tumour was found, apparently associated with the

(a) “Diseases of Women,” Eighth Edition. Pp. 622. London: Baillière, Tindall, and Cox.

uterus, the cavity of which was over five inches in length. The abdomen was enlarged much beyond the size of that of the full term of pregnancy. I operated on September 12th, the patient having a full knowledge

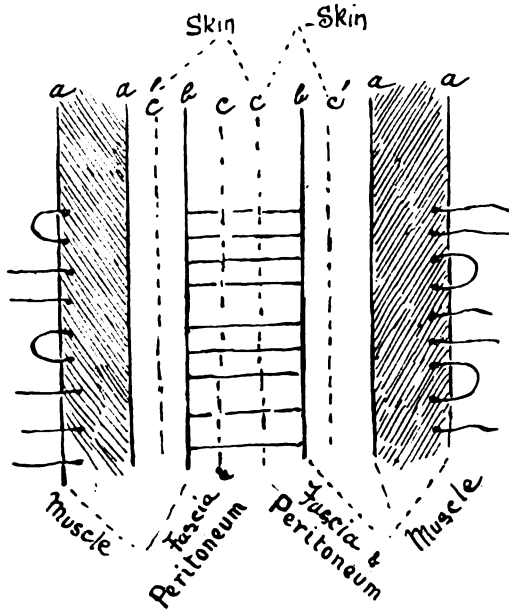


FIG. 3.

of the dangers connected with its removal. The enormous tumour was found free from adhesions,



FIG. 4.



FIG. 5.

pedicle attached it to the left broad ligament, and there was a separate attachment to the uterus. The capsule having been completely detached by a circular incision, and stripped down, the tumour was delivered through an incision reaching from below the ensiform cartilage to the pubes. A broad attachment to the uterus was first secured, and supra-vaginal hysterectomy completed. The broad ligament pedicle was then ligatured in segments, and the tumour detached. After removal it was found that the bladder had been opened. The wound was closed by cat-gut sutures and a catheter retained. The operation lasted altogether for two hours, and during the last half hour subcutaneous (sub-mammary) injections of artificial serum were maintained. The anæsthetic given was chloroform. There was dangerous collapse on the delivery of the tumour, and again towards the close of the operation. As there was some bleeding from the bladder, it was washed out at intervals with a solution containing thirty minims of liquid extract of supra-renal capsule. The tumour proved to be a solid fibro-myoma, and weighed 23½ lbs. Its size and shape can be estimated from the accompanying drawings from photographs (figs. 4 and 5). The table on which the tumour rests measures 16 ins. by 16 ins. (The uterus and adnexa are not shown).

So far, with the exception of some cystitis and pus in the urine, the patient has made an excellent recovery.

## MODERN PROGRESS IN SURGERY. (a)

By WILLIAM TAYLOR, F.R.C.S.I.,

Surgeon to the Meath Hospital and County Dublin Infirmary; Surgeon to Cork Street Hospital; Demonstrator of Anatomy, Royal College of Surgeons in Ireland.

AFTER a few introductory remarks and words of welcome the lecturer commenced his address with the

### SURGERY OF THE BRAIN.

Some few years ago this was a part of the body forbidden to the surgeon's knife, owing chiefly to defective knowledge of its functions, and I may say to almost total ignorance of cerebral localisation. Thanks to the indefatigable industry and perseverance of Ferrier, MacEwen, Horsley, and many others this ignorance has been replaced by a fairly accurate knowledge of function and localisation, with the result that the surgeon now no longer hesitates to open the cranium and explore its contents. Surgical affections, such as tumours and abscesses, are now early recognised, accurately localised, and promptly treated with almost the same precision and accuracy as tumours or abscesses in any other part of the body, and that, too, with a large measure of success. Nor are tumours or abscesses the only conditions for which the cranial cavity is explored, for it is fairly common to see the operation of trephining performed for injury causing fracture and hæmorrhage, leading to compression of the brain—a condition almost certainly fatal if left untreated. Epilepsy, that dreaded condition, especially when due to injury, may also be radically dealt with by operation.

To such an extent have the risks of operation diminished that exploration of the cranial cavity in doubtful cases, rather than leaving the patient to certain death, is not only suggested but actually practised with excellent results by surgeons both at home and abroad. Many brilliant results have been achieved by operative interference in cases of gun-shot wounds of the skull on the battle-fields in South Africa. You may have heard some years ago that craniectomy was the procedure recommended and practised for micro-cephalic idiocy, but rightly this operation had only a short existence. In these cases the whole central nervous system is developmentally defective, and no operation of taking

(a) Abstract of an Address delivered at the Opening of the 149th Session of the Meath Hospital on Monday October 14, 1901.

out slices of the bones of the skull could possibly remedy that defect. There seems to me to be but one condition left in connection with the brain, which may in the distant future, when its pathology is known, become amenable to surgical interference. I allude to insanity. Here I may mention that although the results of injuries to the spinal canal and its contents are not benefited to the same extent by operative interference, still surgery can point with pardonable pride to brilliant achievements in some cases of fracture-dislocation and tumours causing pressure on the spinal cord—aye, and even in some cases of Pott's caries.

#### THE THORACIC CAVITY.

It is not so many years since the radical treatment of empyema became thoroughly established, and to König must be given a good deal of the credit for having so persistently urged the necessity of resection of a portion of a rib as an essential part of every radical operation for empyema.

If pus is present in the pleural cavity to any extent, unless operation is undertaken it can only be recovered from by spontaneously bursting externally or into a bronchial tube, and then expectorated—a by no means a savoury way of draining a pus sac. In very old-standing cases the procedure required is the formidable one of resection of the entire bony wall of the chest. The proposal has been made, and actually carried out in a few cases, to resect the affected apex of the lung in some cases of that disease, which is at present engaging the attention of not only the whole medical scientific world but the public at large, viz., phthisis. Such a surgical procedure seems to me unwarrantable from the results. Cavities in the lung in phthisis and bronchiectasis have been opened and drained with some measure of success in the latter condition. Abscess of the lung and gangrene of a localised nature have been successfully dealt with by surgery. The pericardium is frequently opened now for the drainage of purulent effusions which in former days were left untreated to terminate in all cases fatally. The present position of surgery in these cases, so far as I can gather from the literature of the subject, is this:—Out of fifty-one cases operated upon for purulent pericardial effusion twenty recovered—that is, 35·2 per cent. of cures. Nor does surgery stop with the sac in which the heart lies, for on no less than six occasions the heart itself has been sutured for wounds in man, two of which terminated successfully. Rehn sutured a wound six tenths of an inch in the right ventricle with three silk sutures, while Parozani sutured a wound eight tenths of an inch at the apex with four sutures. These were the two recoveries. Giordani, another surgeon, sutured a wound eight-tenths of an inch in the left auricle with four sutures, and found the wound in the process of cicatrisation at the autopsy, death having resulted on the nineteenth day from empyema. Surely these results of surgical interference in connection with the heart and the sac in which it lies must be looked upon as brilliant.

#### THE SURGERY OF THE ABDOMEN.

It is, however, to the abdomen we must turn for the greatest advances of all in surgery within recent years. No region of the abdomen nor viscus therein can be claimed as exempt from operative interference. The stomach has been not only opened for the removal of foreign bodies, to supply nutrition in cases of œsophageal stenosis, or to remedy the various other conditions of a surgical nature that are amenable to interference through direct incision of the stomach, and not only partially resected, and that with considerable success, too, for the relief of gastric cancer, but for that same fell disease, when more extensive, the entire stomach has been successfully removed. The first case of complete gastrectomy was successfully accomplished in September, 1891, by Carl Schlatter, of Zürich. Connor, of Cincinnati, effected the complete removal as long ago as 1883, but the operation was promptly hushed up on account of the death of the patient, and it is only since Schlatter's success that other similar operations have been performed. As yet the number of cases in which the operation of complete

gastrectomy was performed is too small (only twelve) from which to draw any deduction. Gastric ulcer, with all its complications and sequelæ, has within recent years become an important source of surgical interference. Operation has now been proposed, and has on many occasions been successfully performed, for copious and repeated hæmorrhages from the ulcer.

Operative procedures are now of frequent, one might almost say of daily, occurrence for others of its complications and sequelæ, such as the loosening of adhesions (gastrololysis), or for the relief of pyloric stenosis (pyloroplasty or gastro-jejunostomy), for hour-glass contraction (gastroplasty or gastro-gastrostomy), while gastro-enterostomy is frequently performed for the cure of chronic ulcers that resist other lines of treatment. Perforation, too, has been treated, and with great success, the only essential to success in this latter condition being early diagnosis and rapidity of operation, provided, of course, the surgeon be one experienced in abdominal surgery. Formerly, almost all cases of perforation ended fatally, while now, by timely operation, 70 per cent. at least should be saved. In fact, Keen gives a mortality of only 16·6 per cent. when operation is performed within twelve hours, while for operations performed between twelve and twenty-four hours subsequent to perforation the mortality is more than doubled.

Perforation of the intestine in typhoid fever, formerly looked upon as absolutely hopeless, now shows from 25 per cent. to 33 per cent. of recoveries after timely operative interference. Indeed, in Professor Osler's clinic during the past three years, out of eleven cases operated upon five were saved—a percentage of recoveries of 45·4. This result is attributed to the early stage at which the operation was done. The only contra-indication to operative interference in these cases is extreme collapse. Resection of the intestine for injury, tumour, disease, or gangrene is of almost daily occurrence. A few years ago the infant mortality from acute intussusception was something appalling. Now, in my opinion, there is nothing more successful than the treatment of this condition by laparotomy, provided, of course, the case be seen early and operated upon by a skilled surgeon before the infant is exhausted from pain and vomiting or poisoned by septic absorption from the intestines, and before adhesions have formed. Operations for appendicitis have become, I might almost say, a fashionable craze. Still, I am of the opinion that the earlier we operate for this very common condition the less the risk and the fewer patients will die from general septic peritonitis.

There is one condition in connection with the alimentary tract that still shows an appalling mortality. I allude to acute intestinal obstruction. This seems to me to be due to the pernicious habit of medicine medication and delay until the patient is poisoned by the absorption of septic matter from his intestines, and thus rendered incapable of withstanding any operation. The sooner physicians and surgeons recognise that purgation and delay mean death, and that the only hope of recovery lies in early operation, the sooner this mortality will diminish. The kidney has frequently been successfully removed, and many of you have often seen this organ the subject of operations for the removal of calculi, &c.; but at the present time conservatism comes into sway, and portions only are excised in certain conditions, for which a few years ago the whole organ would have been sacrificed.

Recently Mr. Reginald Harrison has been advocating the exposure through the loin and incision of the kidney for the relief of increased renal tension and vascularity. In other words, he advocates operation, and shows from his own practical experience very good results therefrom in certain cases of Bright's disease arising from scarlatina and cold.

The gall-bladder has likewise been the subject of great surgical achievements in recent years, the pioneer in this respect being Mr. Mayo Robson, of Leeds.

Operations on the liver for hydatids and abscess were of common occurrence, but during the past decade it has been attacked and large portions removed for simple tumours, for cancer extending from the gall-bladder, as

well as in a few cases of primary malignant growth when of a localised nature and early recognised.

In rupture from injury prompt operative action has diminished the rate of mortality from 85 per cent. to 55 per cent. In gunshot wounds the mortality has been reduced from 45 per cent. to 30 per cent., and in stab wounds from 36 per cent. to 25 per cent.

In this connection I should mention that surgery is now invoked by the physician in cases of ascites due to cirrhosis of the liver rapidly recurring in spite of treatment, the object being that of promoting adhesions between the omentum and abdominal wall and between the upper surface of the liver and abdominal wall, and thus forming a new collateral circulation. The spleen, too, has been anchored in its proper place in cases of great mobility, while its conservative surgery in case of injury is now pretty well established, and many cases of complete removal with success have been recorded. Nor has the surgery of the limbs been neglected while these advances were being made in connection with the body cavities. Conservatism has largely replaced amputation. Antiseptic and aseptic surgery have frequently succeeded in dealing successfully with conditions and complications that hitherto were considered ample to justify a mutilating operation such as an amputation is. All other things being equal, the surgeon who has the lowest amputation statistics is the one who is most useful and successful. He who can save a limb is deserving of more credit than the man who can remove it by a brilliant operation performed with lightning rapidity.

Time prevents me entering more fully into the achievements of surgery of the present day, but what I have mentioned will suffice, I hope, to rouse your enthusiasm in connection with the work of the profession into which you have elected to enter. The study of medicine has been divided into two divisions—the first relating to practical usefulness, the second the scientific part.

The former is that which you will chiefly learn and study within these walls, while it is upon this part of your profession most of you will have to depend for the wherewithal upon which to subsist. The second furnishes you with the desire for investigating new phenomena, and establishing on a scientific basis such phenomena as are not already so founded. Surely in either of these you will have sufficient motive to work. Do not imagine from what I have said of the great advances of surgery during the past few years that finality has been reached.

Let me mention to you one subject in which the public are intensely interested, and one which we see more of now than formerly—this increase may be only apparent owing to more accurate diagnosis—a subject the cause of which, in spite of all the observation and investigation which have been expended on it, is still obscure, and consequently the treatment of which, until the cause is definitely settled, cannot be placed on a more scientific basis than with our present knowledge already rests upon. The malady to which I allude is cancer—a word that conveys tremendous significance to the public—a word that generally heralds to the unhappy sufferer his death knell, an extensive and often a dangerous operation alone giving him or her a small hope of recovery without recurrence, and that only when the operation is performed at the earliest stage of the disease. No sphere of life is exempt from the ravages of this malady. It is no respecter of persons, from a ruler to his humblest subject. For him who places the causative factor beyond dispute, and establishes a cure, which it is quite possible may be accomplished by other means than the use of the knife, I may safely predict a place among the greatest discoverers and benefactors of mankind the world has ever known. Scientific fame, social distinctions, and wealth will all be heaped upon him. To acquire a practical knowledge of your profession a fair knowledge of anatomy and physiology, with their ancillary subjects, will be necessary. Then, and then only, will you be in a position to study injuries and diseases, and their immediate and remote results, as exemplified in this and kindred institutions. From the moment you enter the wards or dispensary train your eyes, ears,

and fingers—three of your five gateways of knowledge. You must then learn to draw deductions from the information thus acquired, founding these deductions on your anatomical and physiological knowledge, and thus make your diagnosis. This ability to make a correct diagnosis is the essential difference between an accomplished physician or surgeon and a quack; consequently, unless you can learn to make correct diagnoses, your treatment must be mainly quackery. After this follows the prognosis, to make which, with anything approaching accuracy, can only be done by knowing the different courses the disease may take, by experience acquired by previous accurate observation of similar cases, and by a careful study of the constitution of your patient. In an introductory address, delivered here in 1887 by the late Dr. Arthur Wynne Foot, he took as his text on that occasion the three words, "Industry, Energy, and Perseverance." Any one of these he advised his hearers to take and make it mentally his watchword, and it would prove an amulet or talisman against idleness, waste of time, slothfulness, and all the snares and toils which beset students, and perhaps more especially a student of medicine.

Lord Lytton has well said—"A man will always be eminent according to the vigilance with which he observes and the acuteness with which he inquires." "To this," he says, "must be added perseverance." "I am no believer in genius without labour, but I do believe," he says, "that labour, judiciously and continuously applied becomes genius in itself." Dr. Arnold has said that the difference between one boy and another was not so much in talent as in energy. "Perseverance is energy." Perseverance then, you will find, if you look around and inquire, is the characteristic of all those great men who have attained eminence, whether as statesmen, military or naval, professional or mercantile. Ask Lord Roberts to what he attributed his success as our greatest military general, and he will tell you it was a "tireless attention to minutiae, the undismayed pursuit and study of an idea and all its developments." Ask Lord Lister—one of the greatest benefactors of the race that ever lived—to what he attributed his success in the discovery of antiseptics—a discovery that has so revolutionised surgery, and saved countless lives all over the world—and he will tell you it was perseverance. What was said by Lord Lytton well nigh half a century ago is no less true to-day. Dr. Foot, in the address already alluded to, said: "There is no funeral so sad to follow as the funeral of our own youth, which we have been pampering on selfish or ignoble aims to the neglect of good and wholesome food."

Study then, I implore of you, while yet you have time and opportunity, for every hour and every day you spend in idleness will rise up and confront you with a demand for payment from you of ceaseless yet unavailing regrets. Try and fill your mind with information which will enable you, when necessity and emergencies demand it, to deal effectually and scientifically with the problem before you—a problem which in many cases brooks of no delay, for it is that of life or death.

## ON TRAINED NURSES IN WORKHOUSES. (a)

By M. F. COX, M.D. Hon. Causã. R. U. I., F.R.C.P.I.,  
Visiting Physician to St. Vincent's Hospital.

For some years it has been the custom with each lecturer, at the commencement of the session, to select some topic of general public and professional interest; some abuse to be reformed, or some improvement to be effected, in medical education or in professional status. Army Medical Reform, which I discussed on the last occasion that I had the privilege of addressing you, has been dealt with not wholly satisfactorily, in the recently issued warrant. Time and experience will show its shortcomings. Education, from primary to University, is in the melting pot. We can only hope that something better and more satisfactory than the

(a) An Introductory Address delivered at the Opening of the Winter Session, at St. Vincent's Hospital, Dublin.

past systems may be evolved. There is one question of great and general, public and professional, interest which stands ready, or indeed clamours for settlement. I allude to the question of Nursing in our Poor-law system. The Poor-law system of Ireland has been a subject of almost constant abuse since its foundation. Modelled on the English Poor-law system, perhaps wrongly modelled, it was a subject of bitter attack from the beginning. Its introduction, urged by Dr. Doyle, the famous J. K. L., was bitterly opposed by O'Connell, and by the House of Lords! And yet, assuredly, some measure of relief was necessary for the teeming misery of Ireland in the early part of the nineteenth century. I will not go back to the miseries which followed in the wake of the wars of the sixteenth and seventeenth centuries in Ireland. The condition of appalling misery and degradation which existed in the eighteenth century excited the pity of Arthur Young, and the savage scorn and fierce indignation of Swift. With a vastly increased population the misery of Ireland in the first half of the nineteenth century was still greater. It was estimated, long before the great famine, that for the greater part of every year the enormous number of 2,385,000 people suffered distress, and required relief, in Ireland. This was the estimate of the Commissioners appointed in 1833 to inquire into the condition of the poorer classes in Ireland. They issued their first report in 1835, the year in which this hospital was founded, and a second in 1836. In this latter they thus described the condition of the bulk of the people. "Their habitations are wretched hovels; several of a family sleep together upon straw, or upon the bare ground; sometimes with a blanket, sometimes even without so much to cover them; their food consists of dry potatoes, and with these they are at times so scantily supplied as to be obliged to stint themselves to one spare meal in the day. There are even instances of persons being driven by hunger to seek sustenance in wild herbs. They sometimes get a herring or a little milk, but they never get meat except at Christmas, Easter, and Shrovetide."

That some measure of relief—a great, large, and generous measure—was required to cope with this shocking misery must have been apparent to everybody; and yet, as I have said, the introduction of any Government measure was bitterly opposed by many. Dr. Doyle was one of the earliest pioneers of the movement, and the Irish Poor-law Bill, after much opposition, especially in the House of Lords, ultimately passed, and received the Royal assent on July 31st, 1837. It was not long, however, before the system was destined to be put to an awful test. It is not too much to say that in the world's history no nation has ever been subjected to a more dreadful visitation than Ireland was, in the Famine and Pestilence which raged with slight intermission from 1816 to 1851. Words utterly fail to describe the horrors of that fearful time. Myriads died of famine, the dead and dying lay by the road side, preyed on by birds and beasts, and, in some instances, as after the Elizabethan wars, by one another. Famine and pestilence swept over the country like the breath of a destroying angel. Sir Wm. Wilde, to whom Ireland owes so much, in his invaluable Report on the Census of Ireland for 1851, says: "It is scarcely possible to exaggerate, in imagination, what people will do, and are forced to do, before they die from absolute want of food. For not only does the body become blackened and wasted by chronic starvation, but the mind likewise becomes darkened, the feelings callous, blunted, and apathetic; and a peculiar fever is generated which became but too well known to the medical profession in Ireland at that time, and to all those engaged in administering relief. In this state of what may almost be called Mania, before the final collapse takes place, when the victim sinks into utter prostration from inanition, some instances may have occurred, at which human nature in its ordinary healthy condition, revolts. Thus a Stipendiary Magistrate stated, in extenuation of the crime of a poor prisoner brought up for stealing food, that to his own knowledge before he was driven to the theft, he and his family had actually consumed part of a human body lying dead in the cabin

with them. Generally speaking, the starving people lived upon the carcasses of diseased cattle, and on dogs and dead horses, but principally on the herbs of the field; on nettle-tops, on mustard and watercresser, and even, in some places, dead bodies were found with grass in their mouths."

The entire social system of Ireland was then up-turned; we have it on the authority of Wilde and other competent observers that the people also became entirely changed; the Encumbered Estates Act was introduced, and a social revolution began which still speeds "down the ringing grooves of change." Van Helmont, writing in the seventeenth century, said that the Irish poor were better treated by their physicians than the Italians by theirs.

Our medical men nowadays are, happily, better trained and better educated than formerly. It is also true that the sick are better cared for, and more quickly, as well as more pleasantly, cured. In Dublin and in our large cities and towns throughout Ireland there is, I think, little to be desired in the care of the sick. Throughout the country, however, there is still need for improvement. For the care of the sick poor throughout the country the Irish Poor-law System is responsible; it has been much condemned, and not altogether without cause. That it failed in the baleful blight of the famine is not a matter of wonder; that it was slow to get apace with the times may readily be admitted.

The condition of the workhouses of Ireland until recent years was a disgrace to civilisation and to humanity. Human refuse was shot there with the object, apparently, of getting rid of it, or of hiding it out of sight. Whoever has visited a workhouse, in the past, must have been struck by its cheerlessness and its gloom. There were huddled together Youth and Age, Innocence and Crime, Sane and Insane, no order save that of the barrack-room Lazar, or pest-houses—these mis-called Workhouses were in reality. What now are they to become? Are the deformed to be transformed? The answer rests on three bodies—on the people, who now control them; on the Local Government Board, who control the controllers; and on the Nursing System. I put the last first, leaving the Local Bodies and the Local Government Board to fight it out between them, like gladiators.

Modern Nursing differs from the nursing of the past as modern Surgery differs from Barber-Surgery. I do not mean to say that there were no good, kindly, nurses in the past, or no great Surgeons. "There were great men before Agamemnon," and we still reverence the names of Ambroise Paré and of Florence Nightingale. For the religious Sisterhoods, who, with such splendid devotion and self-sacrifice, take care of the sick and suffering in town and country, I have nothing but praise and admiration. The Sisters of Charity have made this hospital what it is, and I cannot better indicate the relations which exist between them and the staff than by saying that for twenty years, during which I have worked with them, I have known nothing but the most perfect harmony and cordial co-operation. They are ever ready to recognise the need for improvement and reform. Religion, and religion alone, can control and govern, and give order and cleanliness to those institutions, the Workhouses, which are tainted with the evil traditions which they inherit from the past. And working with the Nuns, as allies and assistants, I look to the Nurse who are being trained throughout Ireland, here and elsewhere, to carry on the good work. I hold in the highest esteem and respect the profession of Nursing. It is an honourable and an arduous calling, which requires many great and high qualities. Education, health, fitness, training, patience, tact, self-control, sympathy—these are among the qualifications which go to make a good nurse. I regard nurses as our allies and friends, our assistants and lieutenants, co-ordinate rather than subordinate. I should like them to be our equals in education and social standing, rather than our inferiors. I desire, therefore, that their training should be as complete and perfect as possible, as thorough as it is sought to be made here, and in the other hospitals around us. The higher and more severe the standard,



the better for the nurses and for the medical profession. Before a probationer is accepted here, she has to satisfy the Superiress and the Lady Superintendent of the hospital. After a month's trial she signs an indenture to serve for four years, two in the hospital, and two in private nursing, if thought fit. In her year of probation she serves in the various wards, under different sisters, and in the theatre under the eye of the Lady Superintendent. She receives lectures by the Lady Superintendent, and is examined by her periodically. In the Wards she is expected to be an attentive listener to the special instructions given to junior students. A systematic course of lectures is delivered by the physicians and surgeons, extending over the entire year. At the end of the year examinations of a searching character, oral and written, are held, and whoever fails to obtain 50 per cent. is rejected. Truly it is a searching ordeal. It seems to me that such a system of selection, and of teaching and examination, is as perfect and complete as can be devised or desired. I know we find it to work satisfactorily. It trains the hands and eyes and brains in the varied methods of different men. Such a system is, I think, likely to produce better results than could be obtained throughout the country in the Infirmaries or Workhouse Hospitals, where the material is not usually so varied, and where, as a rule, the services of a skilled Lady Superintendent cannot be retained, and the medical and surgical staff is generally limited to one member. I know the claim has been put forward on behalf of some of the hospitals throughout the country to train nurses.

It has been advanced by men of the highest ability and attainments, such as Dr. Laffan, of Cashel, and Dr. Thompson, M.P., of Omagh. No one recognises more fully, or more gladly, the exceptional ability of these men than I do. They are men who, by their ability would have commanded a foremost place in this or any other city. But I would respectfully suggest that adequate opportunities are wanting to the one, and that the absorbing duties of a Parliamentary representative can scarcely yield leisure to the other. Even so it might be conceded to men of their ability, did it not follow that the like concession should be made to all. I think the Local Government Board have shown a wise reserve in requiring that a trained nurse, having charge of a hospital, must be one who has resided for not less than two years in a general clinical or other hospital recognised by them; who after examination has obtained from such hospital a certificate of proficiency in nursing; whilst, as qualified nurse, or assistant, they recognise any person who after examination has obtained a certificate from any public, general hospital or workhouse infirmary, Fever hospital, or nursing institution, recognised by them as an efficient school for medical and surgical Nurses. As a proof of their zeal and determination we find that the Local Government Board have lately appointed, as an Inspector to inquire into the general nursing of the Workhouse Hospitals throughout Ireland, Dr. Smith, of Naas, one of the ablest of the Poor-law Medical Officers in Ireland. In this hospital we have no interests in the matter save those of the public weal, inasmuch as none of our nurses hold appointments, so far as I know, in the workhouse service. I personally regret this, for I should much rather they remained at home in Ireland and served their own people and their own country than serve strangers. The workhouse system still needs reforms and reformers, and I should be glad to see some of the work done by the capable hands of those whom we have trained. I fear, however, until the sphere of these duties, is made somewhat more attractive, that there will be a difficulty in obtaining the services of high-class Nurses. A lady, unless she has a very special mission, does not like, or rather hitherto did not like—for the system is now changed, and she is only responsible to the medical officer and to the board of guardians—to subject herself to the control of inferior officers, and to isolate and separate herself from companionship with her equals. Besides, boards of guardians, like the rest of us, are not always ideally perfect, and are apt perhaps to consider that the Nurses are having too fine a time of it, and may be giving themselves airs. In this respect, and in many others, lady guardians will be, and are, of

the greatest service. If every Workhouse Hospital could have the generous and self-sacrificing services of such ladies as Miss Rathborne and Mrs. Cosgrave, in the North Dublin Union, the problems which have confronted the Irish and the English Poor-law system would not long present such difficulties.

The Irish Poor-law system will not, in my opinion, be satisfactory until:—

1. The nursing of the sick poor is completely separated from the so-called workhouses. Most of the infirmaries are now part of the workhouses, and are so badly constructed, and saturated with the material of disease, as to be unfit for hospital work.

2. Every dispensary district should have its district nurse or nurses, and cottage hospitals, from which, if necessary, cases might be forwarded to central, well-equipped hospitals.

3. Central hospitals should be manned with a proper staff like our town hospitals, so as to secure healthy rivalry and emulation, and to stimulate to zeal in work.

4. Properly qualified midwifery Nurses should be obtainable in every district. It has recently been sworn that a great sacrifice of the lives of infants and of mothers takes place in remote country districts for want of proper nurses.

Lastly, so far as possible, Consumptive cases should be kept apart from other patients. The Local Government Board, I am glad to see, has recently issued leaflets on this point to the medical officers and to the district and other councils, and have sent posters supplying information with regard to the prevention of Consumption to the people at large. They are thus best performing their duty of safeguarding the public health, and at the same of acting as an educational body. It should be the wish of all of us that they may continue to spread the light in this, and in other such respects, and so earn the respect and confidence of the people with whom, and for whom, they have to work. But it comes, however, to this: that the final authority resides in, and springs from, the people, and on them rests the responsibility, from which they cannot escape, of properly providing for and watching over the sick poor, who are their own kith and kin; of subordinating personal and class interests to the public weal, thus showing their fitness and capacity for the responsible duties conferred on them; by trying to realise in this important matter the great old Roman tradition of the time "when none were for a party, but all were for the State."

## Therapeutic Notes.

By GEORGE M. FOY, M.D., F.R.C.S.,

Surgeon to the Whitworth Hospital, Drumcondra, Dublin.

### DORMIOL.

THE introduction of fancy names for the modern synthetical compounds has the advantage of supplying a word possible of remembrance and one that may be readily written. Of this class of words is dormiol: dimethyl-carbinol-chloral, which Fuchs discovered and which MM. Combemale and Camus so named from its physiological action. The preparation is a good example of the gradually acquired knowledge of the effects of organic radicles of the methyl, ethyl, series of organic radicles, and substitution products of the amide and ester types. To the student of such groups, from their physiological side, the salt from its composition recommends itself as a trustworthy hypnotic.

This theoretical opinion is fully borne out by the practical experience of Metzger, Schulze, Pollitz, Peters, and Claus. In the product the sleep-producing effects of chloral are obtained without any of its toxic effects.

The physico-chemical properties of dormiol are as follows:—It is a clear liquid, of a rather strong peppermint flavour, miscible in alcohol, ether, and chloroform, and soluble in equal measures of water. This allows of a concentrated solution being

administered in capsules, which conceal the unpleasant, pungent taste of the chemical.

The cases most suitable for its administration are those of insomnia from neuræsthenia, melancholia, and delirium, and in such cases its effects are superior to those of sulphonal, trional, or chloral. It has been submitted to a prolonged trial in La Charité de Lille, and in the clinic has displaced the older hypnotics.

Ketly tried the drug on fifty-three patients, and in six cases, four of hysteria and two of tuberculosis, there was no benefit. In a case of epilepsy the drug was believed to have diminished the number of the attacks.

Given in fifteen grain doses daily, Münk used it with benefit, and in doses half the above he found it to relieve the insomnia of cardalgia and asthma.

The pain of enteralgia appeared to be relieved by it, and it was found to lower the temperature of a typhoid case 0.6 to 0.8°.

We think there is sufficient clinical evidence to justify a tentative use of the hypnotic, and if it equals the good report published of it, the profession is to be congratulated on a sleep producer as potent as chloral without its toxic properties, and more than equal to those of the sulphonal series without their uncertainty of action.

## Clinical Records.

### LIVERPOOL (MILL ROAD) INFIRMARY.

*Case of Ruptured Spina Bifida Lumbalis—Immediate Operation for Radical Cure—Recovery.*

By R. DUNCAN CLARK, M.B., Ch.B. Aberd.,

Senior Assistant Medical Officer, Mill Road Infirmary, Liverpool.

ON August 22nd, 1901, H. L., æt. 30, was admitted in labour. At 6 a.m. on the following day she was delivered of a female child, who was found to have a meningocele in the lumbar region, which had ruptured either *in utero* or during birth. From the ruptured tumour, which measured about three inches each way, the cerebro-spinal fluid was freely flowing, a considerable quantity of the exuding fluid being collected. The wound was, of course, foul.

Six hours after birth the child was subjected to general anaesthesia, ether being administered.

Dr. Nathan Raw operated, the method employed being incision followed by excision of the sac. The opening in the skin was enlarged the skin dissected up, and a good deal of what was surplus removed from the edges.

The sac having been removed, the arches of the deficient lumbar vertebræ (2nd, 3rd, and 4th) were united by deep catgut sutures. The skin, together with the muscles and fasciæ, were then approximated by carefully-placed catgut sutures.

The future progress of the case was speedy towards recovery, the wound healing by first intention.

The points of interest in this case were:—

1. Regarding the cause. Prominent writers differ in opinion as to whether the defect in the vertebral arches is a primary one, or is conditioned secondarily upon inflammatory effusions or increase of fluid in the vertebral column. In this case, in which the mother stated she had a fall some time previous to the birth, the history points distinctly to its being of inflammatory origin.

2. The absence of paralysis. In accordance with the location of the tumour, one would have expected to find paralysis of the lower extremities and of the bladder and rectum. This was absent, the child being able to move its legs freely, and to micturate and defæcate without difficulty. Was this accounted for by the tumour having ruptured, and this relieving the pressure which would otherwise have been exerted upon the spinal cord?

3. Pressure on the tumour caused no bulging of the

anterior fontanelle, nor did the fontanelle seem of greater size than normal.

4. General anaesthesia. I administered ether by the open method six hours after birth. The anaesthetic was well borne, and the child made a good recovery, seeming to suffer from no bad after effects. As far as I am aware this is the youngest age at which a general anaesthetic has been given.

I am indebted to Dr. Nathan Raw for permission to publish the case.

## CANCER HOSPITAL.

### *Case of Double Hydrosalpinx. (a)*

Under the care of CHARLES RYALL, F.R.C.S.,

Surgeon to the Cancer Hospital and to the Gordon Hospital for Diseases of the Rectum.

A. H., æt. 35, married, was admitted into hospital complaining of great abdominal pain, vomiting, and excessive loss at the menstrual periods.

*History of Present Illness.*—Five years ago she was seized with sudden acute pain in the abdomen, vomiting, and copious bleeding from the vagina. At this time her period was not due. This attack lasted three weeks, and since then she has had repeated recurrence of this trouble. The attacks have been coming on with increasing frequency and severity, and one attack may follow another after only an interval of two weeks. There has been much loss of flesh. The catamenia are irregular, excessive, last seven to eight days, with the passage of large clots.

Her past history was fairly good with the exception of three miscarriages, the last being seven years ago.

*On examination* there was great tenderness in the right iliac fossa. An elastic, uniform rounded tumour could be felt rising out of the pelvis to within one and a-half inches of the umbilicus. Bimanually it was found presenting in Douglas's pouch, and even its very limited mobility showed it to be intimately connected with the uterus. The sound could be passed three and a-half inches.

*Operation*, October 1st, 1901.—The abdomen was opened in the median line, the omentum was found adherent to the parietes. The tumour was hidden from view by adherent coils of small intestine, and on freeing these a double hydrosalpinx was found, the right distended tube lying at the bottom of Douglas's pouch, and tightly adherent there, and overlapping this was the left hydrosalpinx. The latter was first dealt with and removed by enucleation after division of the peritoneum of the meso-salpinx. The right tube was removed *en masse*. The tumour on the left side was about the size or an average cocoa-nut, and that on the right as large as a big pear. There was a good deal of oozing from the breaking down of adhesions, and also from the sac of the left distended tube, so drainage was resorted to. This was accomplished by making an opening through the posterior fornix into the vagina, and the oozing sac was also drained by making an opening through the posterior surface and carrying a strip of gauze from this into the vagina. The abdomen was closed in three layers, the drain removed in forty-eight hours, and the patient made an uninterrupted recovery.

## Transactions of Societies.

### CLINICAL SOCIETY OF LONDON.

MEETING HELD FRIDAY, OCTOBER 25TH, 1901.

CLINICAL EVENING.

MR. HOWARD MARSH, F.R.C.S., President, in the Chair.

RIGHT SIDED HEMIPARESIS WITH ATROPHY OF LEFT OPTIC DISC.

DRS. RAYNER BATTEN and LEONARD GUTHRIE showed a boy, æt. 12, who fractured left femur in October, 1900. Whilst laid up had a doubtful attack of acute rheuma-

(a) Read before the Brit. Gyn. Society, October 10th, 1901.

tism. In February, 1901, noticed weakness (gradual) of right arm and legs, difficulty in writing and walking. When seen on April 30th, 1901, weakness, ataxy, and intention tremors noted in right arm. Right leg wasted, knee-jerk exaggerated, ankle-clonus marked, and typical Babinski's plantar reflex present. Sensation normal. Gait hemiplegic in type. No facial paralysis. Faint presystolic bruit present. Dr. Batten noted (June) that "the left optic disc was pale and excavated. Cribiform plate exposed at bottom of excavation. Disc not filled in nor opaque. No blurring of vessels or of margins of optic disc. Well-marked central scotoma for white (no colour perception). Retina in macular area and up to optic disc showed signs of disturbance and a number of fine white dots. Veins somewhat large, dark, and tense." The right optic disc was normal. No hemianopsia. *Remarks.*—Nature of case is obscure. Patient may have had thrombosis in neighbourhood of left motor tract with recto-bulbar neuritis of left optic nerve, or the condition may be due to early disseminated sclerosis. May be compared with case shown at Clinical Society's meeting, October 28th, 1898, vol. xxxii., page 228, in which complete left hemiplegia and white optic disc existed. The condition followed convulsions (post-partum), and was believed to be due to embolism or thrombosis of right Sylvian artery and of arteria centralis retinae.

Dr. F. E. BATTEN recalled the case of a girl, *et.* 25, who developed very similar symptoms, but recovered to some extent, though she remained aphasic and with left-sided loss of vision. Mr. Gunn in this case reported whiteness and flatness of the disc, which had sharp margins, suggestive of thrombosis and hæmorrhage into the sheath of the nerve. She died some months later, and post-mortem there was found thrombosis of the left and middle cerebral artery with thrombosis of the vessels of left optic nerve, which was much degenerated.

#### A CASE OF GLENARD'S DISEASE.

Dr. J. P. PARKINSON showed a married woman, *et.* 40, the mother of five children, who came to the hospital for symptoms due to stenosis and regurgitation of the mitral valve and cardiac dilatation. The abdomen is very large and flabby from relaxation of the muscles of the abdominal wall. When lying on the back the lower limit of the finger can be felt a finger's breadth below the level of the umbilicus, and its dullness above extends to the costal margin, but in the erect position it falls to a much lower level. It can be freely moved about between the two hands. The spleen is also felt to be somewhat enlarged, prolapsed, and movable. The right kidney can be easily felt as a movable mass below the right limit of the liver, from whence it can be pushed back into the loin. The left kidney appears to be normal in position. The stomach seems to lie somewhat below its usual level, and to be slightly enlarged. For a week in the middle of June the patient suffered from a constant pain in the right loin, which extended from thence to the anterior superior iliac spine, and during this period the urine, which previously had contained only a trace of albumen, diminished to half its usual amount, and contained two-fifths of albumen. When the pain ceased the albumen and, for a few days, the amount of urine increased to three or four pints daily. This temporary interference with the functions of the kidney was the only symptom referable to the large amount of visceroposis present.

#### CASE OF CONGENITAL ABSENCE OF BOTH CLAVICLES.

Dr. SEYMOUR TAYLOR showed a man, *et.* 20, clerk, in whom both clavicles were incompletely developed. On each side the sternal ends, with the attachments of the sternomastoid muscles thereto, can be felt; and there would appear to be some attempt at development towards the acromial end. The intervening space is occupied by what would appear to be fibrous structure, possibly representing the costo-coracoid membrane. The upper limbs are not impeded in their various movements; indeed, the patient had no previous knowledge of his defects. On the other hand, he can throw a ball and play cricket as well as most youths. Both shoulders can be so far approximated to the middle line that the

eminences of the deltoid muscles can be made to touch each other. The condition thus approaches that of the carnivora.

#### A CASE OF HYDROPS ARTICULI.

Mr. F. C. WALLIS showed an elderly man who was the subject of hydrops articuli complicating osteoarthritis. His ligamentum patellæ had been ruptured; previous to that the patella had been twice fractured; it can now be felt some distance up the thigh. The large fluid swelling in front of the joint has been aspirated three times, and pressure has been applied. This had had no effect in reducing the fluid, and he had ceased to trouble about it. The comparative ease with which the man gets about with so disorganised a joint was, he thought, no doubt helped by this fluid condition of the joint cavity.

#### CASE OF ACUTE INTUSSUSCEPTION.

Mr. F. C. WALLIS showed an infant, *et.* 7 months, on whom he had operated successfully for acute intussusception of the ileo-cæcal variety. Was admitted with somewhat obscure symptoms of intestinal obstruction, and the operation was performed thirty-three hours after the first onset. On section the intussusception, which occupied the situation of the hepatic flexure of the colon, was drawn out of the incision, and by gentle traction and pressure it was gradually reduced. The intussuscepted gut was seven inches long, quite collapsed, somewhat congested, and thickened. After reduction the intestine was returned to the abdomen, and the abdominal incisions closed by one row of sutures. The operation lasted twenty minutes. The bowels acted next day. Recovery was uninterrupted except that the infant was unable to digest any peptonised or other milk, but when the mother recommenced to feed it this trouble ceased.

Mr. BARKER suggested a small incision, and the introduction of one finger, for the gradual reduction of the intussusception by the method advised long since by Mr. Jonathan Hutchinson.

#### CASE OF LEONTIASIS OSSEA.

Mr. H. BETHAM ROBINSON showed a male, *et.* 26, who displayed very hard, almost symmetrical swellings on the nasal bones and adjacent parts of superior maxilla. The nasal chambers are almost completely blocked, the turbinates being pushed towards the septum. The swelling first appeared on the left side in 1897, and progressed slowly. No pain. No watering of the eyes. No history of syphilis. He has been in South Africa since the lesions appeared. The remarkable feature of the case is its strong likeness to "henpuye" or "dog-nose" of Cape Coast Colony.

Mr. CHARTERS SYMONDS referred to a very similar case in which nasal obstruction was a prominent symptom, the intra-nasal swelling being symmetrical though more marked on the left side, and it extended into the upper jaw. The condition was of some eight or ten years standing. He cleared the nostrils and the man derived much benefit, the ultimate result being very satisfactory. No recurrence had taken place. In another case operative intervention also greatly benefited the patient so that evidently something could be done to afford relief in these cases.

Mr. BOWLEY suggested that probably many cases included in this term had little or nothing in common with true leontiasis. Some were cases of what had been called generalised osteoma, while in others the growth was strictly localised to a particular portion of the superior maxilla on each side.

Mr. KEETLEY had operated on two cases of one-sided nasal obstruction, and remarked that in the author's case the growth was at first unilateral. In neither case was there any tendency to recurrence. He commented upon the difficulty of knowing how much bone to remove when the soft tissues had been detached.

#### PULSATING TUMOUR OF THE SACRUM.

Mr. CHARTERS SYMONDS showed a man *et.* 65, who came to Guy's Hospital complaining of pain in the sacrum. On rectal examination a pulsating tumour could be felt high up, covering the whole width of the sacrum, and reaching rather further to the right. The pulsation was controlled

by compression of the aorta. Through the sacrum a loud systolic bruit was heard. The patient had also outward displacement of the left eyeball, and this was associated with antral suppuration. It has remained stationary for a long time. The rectal wall is quite smooth, and the edge of the growth is sharp. It was suggested that the pulsating tumour was a growth secondary to that in the ethmoid.

Mr. WALLIS thought the tumour might possibly be of a nœvoid character. He asked how long the eyeball had been displaced, and whether the displacement was increasing?

Mr. BARKER asked if the rectum had been examined with a speculum, which would enable the nœvoid character to be perceived, and he referred to such a case in a man, age 40, who ultimately died of hæmorrhage.

#### SYPHILITIC MYOSITIS OF THE EXTENSOR CRURIS.

Mr. CHARTERS SYMONDS also showed a man already exhibited last session. Doubt was then expressed as to the nature of the case, some thinking the condition to be a new growth. In the interval rapid improvement has taken place, preceded by involvement of the skin. The patient was unable to submit to treatment by rest, and for a time was without medicinal treatment. When he returned there was effusion into the knee, and signs of advancing disease, and the skin was broken in several places. Large doses of iodide produced rapid improvement, so that the diagnosis can no longer be regarded as doubtful.

#### ARTHROPATHY IN A CASE OF BRONCHIECTASIS.

Mr. H. E. SYMES THOMPSON, M.B., (for Dr. Percy Kidd) showed a young woman, æt. 26, single, who since eighteen months has had symptoms of chronic bronchitis, the sputum being offensive from the first. Twelve months ago the sputum became more offensive and more copious, and about this time the ankle joints first became affected. Subsequently the wrists and knees were involved. Both wrists are now swollen, stiff, and tender. No creaking. The fingers are also somewhat swollen. Much muscular atrophy. Knees slightly swollen and contain a little fluid. Ankles enlarged, but not tender at present. Muscular wasting well marked. Physical signs of bronchiectasis well marked at left base. Sputum, formerly very offensive, has now no fetid odour, and the quantity has greatly diminished.

Mr. BOWLEY remarked on the interest of the case, in that it threw light on a group of cases closely allied in appearance to osteo-arthritis, but which were of septic origin.

Dr. S. TAYLOR asked how the author explained the present absence of fœtor in the sputum, and to what cause he attributed the patient's recovery?

Mr. WALLIS recalled a case of ulceration of the rectum in which there had been several well-marked attacks of arthritis. As the ulceration healed the arthritis subsided, and in spite of exposure had not since recurred.

Mr. SYMONDS recalled a case of severe septic throat culminating in abscess in which the patient developed septic arthritis of several joints.

#### HARVEIAN SOCIETY OF LONDON.

MEETING HELD THURSDAY, OCTOBER 17TH, 1901.

The President, Dr. D. B. LEES, in the Chair.

MR. CAMPBELL WILLIAMS, F.R.C.S., read a paper on  
HÆMATURIA IN CHILDHOOD,

which appeared in our last issue. In the discussion that followed, Dr. SIDNEY PHILLIPS remarked that hæmaturia, arising from tuberculous disease of the urinary organs, especially when the kidney was affected, might be very profuse. He had not seen hæmaturia in scarlet fever except as part of an acute nephritis. In a patient suffering from typhoid and scarlet fever at the same time fatal hæmaturia had occurred, and was shown *post mortem* to have arisen from the bladder wall. In children it was not infrequent to get hæmaturia which seemed attributable to the mechanical action of crystals of oxalates or of uric acid found in the urine. He thought

hæmaturia and epistaxis might result from the rheumatic poison.

Mr. BUCKSTON BROWNE referred to the completeness of the paper, and said he could only think of one source of hæmaturia in children which had not been mentioned, namely, the bursting into the bladder of an abscess, connected either with the hip or the spine, and he instanced a case where he had removed part of the body of a vertebra from the bladder into which it had been discharged from a spinal abscess. He mentioned a case of infantile hæmaturia seen with Sir Thomas Barlow, where the cessation of the use of sterilised milk, and the taking of a little orange juice, were followed by excellent results, and he asked Mr. Campbell Williams if after juvenile suprapubic cystotomy he compelled his patients to assume any particular attitude, some surgeons having insisted upon the prone position, while he preferred to allow the child to lie as it liked.

Dr. G. A. SUTHERLAND agreed with the author that hæmaturia did not occur in uncomplicated rickets. In scurvy hæmaturia might occur from renal or vesical hæmorrhage, and was directly dependent on the general disease. In some cases, however, he thought a local cause existed in the form of mechanical irritation of the kidneys by uric acid crystals. These were frequently passed in large amount in scurvy, as in most affections characterised by profound anæmia. So that, if hæmaturia were the sole evidence of the hæmorrhagic tendency during an attack of scurvy, it was advisable to examine the urine carefully for uric acid.

The CHAIRMAN and Mr. RAYMOND JOHNSON also took part in the discussion, and Mr. CAMPBELL WILLIAMS replied.

### Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, October 26th, 1901.

At the Society for Psychiatry and Nerve Diseases, Hr. Cassirer related a case of

#### ABSCESS OF THE MEDULLA OBLONGATA AND PONS.

The first certain case was described by Meynert in 1863. Then followed two cases by Eisenlohr and one case by Lorenz and Dagliotti. The case now recorded was observed in the Charlottenburg Hospital. A man, æt. 30, was received into the hospital on January 20th; he had then been suffering from fever since the 8th of the month. On January 22nd paræsthesia appeared in the left arm and leg, and on the 24th there was diplopia. The sensorium was free. On the left side there was hyperæsthesia from the head to the foot from the middle line outwards. The facial was free, and there was slight paresis of the abducens of the right side. Both temperature and sense of pain were much disturbed. There were subjective feelings of creeping and cold in the left leg. Mobility was undisturbed. The temperature rose to 41.6° C. On the following day optic neuritis came on with increase of the paresis of the abducens, and right facial paralysis. Death took place on the 29th, before which, however, right-sided keratitis had come on.

On transverse section through the pons, near the right of the trigeminus, a collection of pus was found the size of a cherry. There was some pus in the fourth ventricle, no meningitis. Microscopical examination showed that a pus collection had formed at the right dorso-lateral corner of the medulla, at the level of the origin of the facial nerve, and immediately below the floor of the fourth ventricle. In many places was an almost immediate transition from normal to purulent decomposed tissues without the intermediate stage of red softening, and in other places the characteristic appearance of the latter without purulent breakdown.

Hr. Grawitz reported on the clinical features of the case. As regarded aetiology, there were no points from which any conclusion could be drawn. The patient had a cutaneous eruption that reminded one of syphilis. There was extraordinarily high temperature, anaesthesia of one side, and symptoms on the part of the abducens and facial on the other, symptoms on the part of the trigeminus that drew attention to the part found later on to be affected. On his attention being drawn to the great rarity of abscesses of that region the thought came to his mind that the case was one of multiple abscesses, and it was interesting to note that multiple abscesses were found in the liver, although clinically there had been nothing to indicate their presence. The whole intestinal tract was unaffected, except that in the vermiform appendix a fish bone, considerably changed, was found. A distinct ulcer was also observed there. The speaker was of opinion that the patient had passed through a masked attack of perityphlitis, giving rise to septic inflammation which had passed from the liver, and had then led to multiple abscesses. A pyaemic process had now been set up in the lungs and in the medulla and pons which had eventually predominated over all other symptoms.

#### THE DISINFECTION OF CUTTING INSTRUMENTS BY MEANS OF SPIRIT OF SOAP.

The *Deut. Med. Woch.* contains an account of the method of disinfection by Dr. J. H. Polak, of Amsterdam. First of all the author satisfied himself by actual experiment that the most certain of all practicable methods of disinfecting cutting instruments was by boiling in a soda solution in a closed vessel. For complicated instruments and such as are not damaged by boiling this method remains the best. Spiritus saponis kalinus destroys direct staphylococci within fifteen minutes. It therefore became a question whether this material should not replace boiling, which certainly damages cutting instruments. The soap spirit is also an excellent material for the mechanical cleansing of instruments, when carefully performed and continued for at least half a minute. The cleansing takes place not only when the instrument is rubbed with a cloth soaked in the soap spirit, but also in a soap bath, which causes the blood or pus to swell out and soften. The combined chemical and mechanical method can therefore be safely recommended for disinfecting cutting instruments. Alcohol 50 per cent. in strength is more efficient in disinfecting than a weaker or stronger solution. The author forming his conclusions from the observation mentioned proceeded to disinfect his cutting instruments by means of Straub's soap spirit. It soon became evident that the instruments did not lose their sharpness as they did when boiled.

The method now adopted is the following:—After every operation the instruments are placed in the soap spirit and kept in at least fifteen minutes. They are then taken out and carefully cleaned. Before an operation they are again placed in the soap spirit for fifteen minutes. They are then wiped with a sterile cloth. The soap may also be removed by placing them in a 50 per cent. solution of alcohol or one of sterile boracic acid. It is of great importance to place the instruments before and immediately after an operation in a 3 per cent. sterile solution of boracic acid. Geron's advice is also considered excellent, viz., to wrap them in a cloth soaked in the soap spirit; so that disinfection

takes place whilst they are carried about, or at any rate they are undergoing a preparation for the final cleansing.

#### AN UNUSUAL CASE OF SELF-INJURY.

The *Militararzt*, 26/7/1901, relates the following:—A recruit was admitted for treatment suffering from numerous ulcers on the feet and lower limbs. The circumstance that all the ulcers had dry, brownish-red scabs, firmly adherent at the edges, led to the conviction that they were caused by some corrosive substance. In the man's haversack the leaves of a kind of ranunculus were found, and a head of garlic. He now confessed that he had used these plants in the hope of being discharged from military service on account of the ulcers they set up.

The ranunculus contains a volatile oil-like material of a yellow colour, which decomposes into ammoniac acid and ammonium, the latter being an irritant. The garlic contains mustard oil. Both plants are therefore capable of causing superficial ulceration.

### Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, October 26th, 1901.

#### SYNTHETIC FORMATION OF URIC ACID IN THE ANIMAL ECONOMY.

WEINER has been experimenting on birds and dogs, which he fed on nitrogen-free aliments—at the same time injecting urea, and he finds that uric acid is formed in the urine with other nitrogenous compounds without affecting tissue metabolism.

The substances used for food were glycerine, oxim and keton—bibasic acids, with a combination series of three atoms of carbon, which greatly increased the amount of uric acid normally eliminated.

The greatest amount was passed with the bibasic acids, or those nearest allied thereto in chemical composition. Similar results were obtained in the mammalia, but the quantity was smaller, while the urine contains turbates and urates in the form of dialurates. In the normal condition this chemical change does not take place, but only in a pathological state such as gout, &c.

#### TETANUS FROM ANTIDIPHTHERITIC SERUM.

Peterka related the history of three cases of tetanus resulting from the employment of anti-diphtheritic serum. In many cases whole groups of muscles are attacked, such as the quadriceps femoris, abdominal and dorsal muscles, according to site selected. The facial, masticatory and neck muscles are secondarily affected. It is not, however, common for the tetanus to commence in the immediate neighbourhood of the injection wound in children, as it is more rapidly diffused, although the reason thereof cannot be clearly explained.

#### CUTANEOUS ACTINOMYCOSIS.

Kopfstein relates a case of actinomycosis occurring on the hand of a female, from a cut between the thumb and index finger, which was inflicted while binding sheaves in harvest time by a spike penetrating the skin. The wound rapidly healed, but five weeks after a hard, non-painful swelling, about the size of a walnut, formed over the site of the wound. After nine months it was extirpated and found to be composed of sclerotic tissue, within the meshes whereof was found a fine granular tissue, with a few drops of pus containing the radiated fungus and fine granules.

## AUSCULTATION OF MUSCLES.

Herz has long been applying himself to the diagnosis of disease by the tone of the contracting muscle, just as it is observed in the contraction of the cardiac muscle, the energy whereof can be measured from the lowest to the highest grade. In pathological conditions these changes can be observed by the ear in every muscle of the body.

He admits having met with one case of Thomsen's disease in which no sound could be discovered.

## DIAGNOSIS OF OESOPHAGEAL SACS.

Zweig assures us that he has solved the difficulty of diagnosing diverticula of the œsophagus when located down the canal. He places one catheter in the sac and a second in the stomach. Through the second he passes a solution of methyl blue and then withdraws the first, which should contain some of the fluid if in the stomach. If it be simply a dilatation of the canal the coloured fluid must be found in the stomach. He records four cases of diverticula which could only be diagnosed in this way.

## POLITZER'S OHRENHEILKUNDE.

Another edition of Politzer's text-book, with 710 pages, has just appeared. Many of the subjects have been rewritten, such as Chronic Affections of the Middle Ear, &c., while Menière's disease is critically examined as an apoplectiform affection which requires to be distinguished from the complex symptom of the same name.

## PYOCYANEO-PLASMIN.

Honl and Bukovsky have been engaged in some practical experiments with the bacterial flora that promises to be of some use in the treatment of ulceration of the legs and other solutions of cutaneous continuity. On examining the product of these ulcers, they found small numbers of bacillus pyocyaneus, staphylococcus proteus, bacterium coli, and Friedländer's pneumococcus. With the hope of removing these they tried the proteids and products of the different bacilli. The most effectual of these experiments was conducted with the products of the bacilli pyocyaneus, which they have designated pyocyano-plasmin, or pyocyaneo-protein. If two or three compresses of this product were applied daily to the ulcer, healing could be obtained in sixteen to fifty-seven days. Within twenty-four hours of the application of the toxin the secretion becomes very scanty, and in from one to ten days there is a clean granulating surface, which soon becomes covered with a permanent layer of epidermis.

To illustrate the advantage of this treatment they have taken Prof. Janovsky's results for five years to compare with the pyocyaneo-plasmin treatment.

In 1892,	56	per cent.	were healed,
In 1893,	60	"	"
In 1894,	47	"	"
In 1895,	52	"	"
In 1896,	57	"	"

while the toxin-therapy has 90 per cent. to its credit.

## The Operating Theatres.

## GREAT NORTHERN HOSPITAL.

OPERATIONS FOR SUPPURATIVE PERIOSTEITIS OF THE FEMUR.—MR. PEYTON BEALE operated on a girl, æt. about 10, whose history was as follows:—Four days prior to admission she had received a blow about the middle

of the left thigh. This was followed by a good deal of swelling of the soft parts, and intense pain deep down in the thigh and in the knee. On admission the girl was found to have a temperature of 103°, with a large inflammatory swelling occupying the middle third of the thigh; the patient had the appearance of being very acutely ill. It was decided to make an incision down to the femur at once, and this was done on the antero-external aspect of the limb with the escape of about a teaspoonful of thin pus; on the finger being inserted into the wound, the periosteum was found stripped from the bone around its whole circumference for a distance of about five inches. A counter-opening was made on the posterior aspect of the thigh, and a plug of gauze passed right through and the wound dressed in the ordinary way. After this first operation there was very little improvement in the child's general condition, the temperature reaching every night to 103° or 104°; she was put upon large doses of brandy (12 ounces in twenty-four hours), and during the next week or two several metastatic abscesses appeared in the scalp, in one ankle, and in one wrist. These were dealt with by being opened and drained in the usual way and soon healed. The child continued in much the same general condition, and about four weeks after the first operation nearly the whole of the diaphysis of the femur, &c. (six inches in length) was found to be quite loose, and was easily removed by enlarging the original wound upwards and downwards. The large cavity thus formed was washed out and drained with a gauze plug, and an extension put on the leg. After this operation the patient very rapidly improved, the temperature at once fell to normal, and the wound healed completely in about three weeks time. The extension was rigidly enforced until six weeks after the second operation; at this time the shortening was not more than two inches, and as new bone was felt filling up the whole interval left by the removal of the sequestrum, the child was allowed to get up and walk by the aid of one crutch. Mr. Beale said that this belonged to a class of cases often now known as acute necrosis; the cases were very remarkable owing to the pathological conditions which were found to be present. The patients were generally children between the ages of three and twelve in an unhealthy condition; the long bones, such as the femur, humerus, and tibia were the ones generally attacked. There was often a history of a slight injury such as a blow or a kick, but very rarely was there a wound present. It was also noticed that the disease was frequently epidemic in a certain neighbourhood. The disease appeared to start by bacterial invasion of the periosteal blood vessels, for it was generally to be noted that when the first incision down to the bone was made in these cases a large extent of the periosteum was found to be stripped, and at this early stage there was very little pus, in fact often nothing but slightly turbid fluid. He believed that the stripping of periosteum did not as a rule advance after an incision for the relief of tension had been made, obviously, therefore, it was of the utmost importance to diagnose such cases as early as possible, and to make an incision straight down to the bone; if an incision was not made early, he pointed out that pus generally burst through the periosteum and spread along the intermuscular planes if the

patient lived long enough for that to occur. It might be urged, he remarked, that [the best treatment was to remove at once as much of the bone as was found to be denuded of periosteum, but he said the following were the objections to this method: 1. It involved a very large incision through healthy tissues which were almost certain to then become infected, and the shock of so extensive operation was generally fatal. 2. It was impossible to tell how much bone to remove, for in many cases the periosteum might become adherent again at the upper or lower ends or both, and the bone would not necrose. Again, if one removed only a small portion a subsequent operation would become necessary in order to take away necrosed fragments. 3. The disease was a general and not a local one, as shown by the almost invariable formation of metastatic abscesses, and under those conditions one would not get rid of the disease by any radical operation at the outset. He knew quite well that by leaving the bone *in situ* until it had separated as a sequestrum, the patient's general condition must remain bad, but, brandy in large doses was extremely well borne by children in this condition, and his experience in many cases of the kind proved that they never succumbed to the effects of bone which was undergoing necrosis being left *in situ*. Directly the sequestrum was found to be quite loose it was easy to remove it through a comparatively small wound, as it could be broken up into fragments by strong cutting pliers, and generally there were very few, if any, spicules left behind. When this had been done the patient always appeared to recover very rapidly, and if extension were carefully and efficiently maintained exceedingly good results were to be obtained. It may, he remarked, be noted in the above case that although six inches of femur had necrosed, the amount of shortening was comparatively small. He also pointed out that the disease rarely, if ever, attacked the epiphysis of a long bone.

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## The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, OCTOBER 30, 1901.

### SANITATION IN ARMY MEDICAL REFORM.

Now that there appears to be some prospect of reducing the Army Medical Service to the standing of a business-like organisation the time seems fitting

for the discussion of the circumstances of the position. The recommendations of Mr. Balfour's Committee may be summed up shortly as an attempt first, to induce outside medical men to join the Service, and, secondly, to raise the scientific status of the Army medical officers by choosing those who have passed the high-standard examinations. As to the first proposal it would clearly be more to the point if attention were concentrated mainly upon removing existing grievances and making the Service as attractive as possible to those who are already in its ranks. As to the second point we altogether refuse to believe that the brilliant reflector-like brains of the high-standard pass man are likely to furnish good sound practitioners for the Army or for any other kind of general practice. The trustworthy man in the battle against disease is he who is armed with principles against details pure and simple. An encyclopædic knowledge of the latter is the sole test demanded by the high-standard examiner. To our mind it is beginning at the wrong end of the stick to seek to fix the capability and fitness of candidates for the Service by their simple capacity for cramming wholesale the minutiae, often purely theoretical, of other men's speculation and knowledge. The newly-qualified man has done nothing more than lay the foundations of his professional knowledge, and if he found his future career upon the shifting sands of a high-standard examination then his edifice is likely to be of an unstable nature. As we have pointed out on previous occasions, the later or post-qualification educational opportunities of the Army medical officer are limited. For one thing, he lacks the incentives of competition and of the struggle for existence that are imposed upon his civilian brethren. That part of the situation has been recognised in the report of the Committee by the recommendation to increase the facilities for study-leave. The great flaw in the suggestions of that body of inquiry, however, appears to us to be in the point of sanitation. There is no single matter, either in times of war or of peace, in which the Army medical officers are required to play a more important part than in that of the prevention of disease. The mortality to our standing army in military quarters, not only in India and tropical stations, but also in the midst of the great centres of life here at home in the United Kingdom, constitutes a reproach to the Service whose duty it is to attend to such things. The absolute and utter breakdown of the Army Medical Service in dealing with enteric fever in the camps of South Africa need not be dwelt upon. In spite of the whitewashing of Mr. Balfour's Commission and the public utterances of distinguished medical consultants “back from the war,” the main facts of the scandals exposed by Mr. Burdett-Coutts stand unshaken. Recrimination, however, we are happy to believe, is not the mood of the British nation any more than it is of the medical profession. The demand for Army medical re-organisation is now universal, and clearly there can be no point that de-

serves more wisdom and thoroughness than the subject of sanitation. Here, again, in our opinion, what is wanted above all things is practical experience. The art of sanitation can no more be learnt from books than any other branch of applied medicine. The brilliant man in spoken and written disquisition, as all practitioners know, is apt to be useless at the bedside. Away from the patient he knows everything that even a high-standard examiner could wish him to know, but when brought into action his attack is ill-directed, feeble, and wavering. No amount of book learning will make a competent sanitary medical officer either in or out of the Army. The way out of the wood is not altogether easy to find. With a little management, however, it would, perhaps, be possible to arrange that at some period of their career every army medical officer should pass a year or more under the nearest civilian medical officer of health. In London, for instance, and in other great garrison towns there would be little difficulty in the officer devoting several hours daily to such a purpose. Or six months of sanitary pupilage might be made a condition of entrance to the Service. In any case we think that the department should be strengthened by the selection of a certain number of experienced medical officers of health who should undertake the general supervision of all military quarters, and whose duty it would be to maintain the sanitary competency of all medical officers. The details of this important part of Army administration can be worked out without any great difficulty if the War Office can only be induced to recognise the supreme importance of sanitary knowledge in maintaining the health of the Army.

#### THE SURGICAL TREATMENT OF ASCITES DUE TO HEPATIC CIRRHOSIS.

THE ordinary treatment of ascites due to cirrhosis of the liver has always been regarded, and with reason, as beyond the scope of practical medicine. We are confronted with more or less extensive organic changes which seem to defy medicinal or other treatment. A mechanical obstacle has been introduced in one arm of the circulation over which all therapeutical measures are of no avail, and afford at most but a fleeting and fallacious relief. It is indeed so unsatisfactory that physicians have every reason to be grateful to surgeons for seeking to afford a relief which is not obtainable by medicinal means, that is to say, by modifying the anatomical relations of the abdominal viscera, or some of them, in order to permit of the re-establishment of the circulatory equilibrium. The method under consideration has for object to relieve the circulatory embarrassment by setting up adhesions between the surface of the liver and the surrounding structures with the object of establishing a collateral channel for the return of the blood. Theoretically this plan offers a means, and so far as our knowledge goes, the only means of providing an alternative passage for the blood which is dammed back by

the cirrhotic parenchyma of the liver, and although the results so far have not been altogether encouraging, we are entitled to hope that further experience will show how the operation is best carried out and in what class of cases it is likely to be attended by success. It is necessary to draw a distinction between the cases according as there is ascites only or ascites associated with œdema or anasarca. The latter cases usually run an extremely rapid course to a fatal termination, and therefore do not afford much chance of a successful intervention. They are, moreover, for the most part cases in which there is concomitant disease of other organs, either as the direct result of the hepatic change or as part and parcel of wide spread tissue change of which cirrhosis of the liver is only the most prominent manifestation. This latter condition is, indeed, the gravest argument advanced against the probable efficiency of surgical intervention. It is stoutly maintained by certain authorities that cirrhosis of the liver is but one factor in a constitutional impairment in the same way that granular kidney is one of a number of organic changes which together determine the symptoms associated with this disease. There is unquestionably some truth in this contention, and it remains for surgeons to demonstrate by results that the collateral changes are not in themselves incompatible with prolongation of life if only the mechanical obstacle to the circulation through the liver can be circumvented. One reason why the operation has not so far given the results that had been hoped of it is doubtless that it has hitherto only been undertaken on patients as a last resort, patients who were almost moribund before they were offered this last chance of relief. The operation itself is simple enough. It comprises a small incision in the median line above the umbilicus, the higher the better in order to avert the risk of ventral hernia which has carried off more than one of the patients reported as cured. The surface of the liver is then scrubbed with a plug of gauze sufficiently to excite agglutinative inflammation which brings that organ into vascular intimacy with the adjacent structures. The evidence points to the necessity for undertaking the operation much earlier in the course of the disease than has hitherto been attempted, in fact as soon as possible after the presence of fluid in the abdomen has been made out. The onset of ascites marks the terminal stage of hepatic cirrhosis, it indicates that the circulation can no longer be efficiently carried on, so that there is no valid reason for delay. Anything would be preferable to the miserable end which awaits these patients once the circulation fails, for the benefit of tapping, purgation, &c., is so ephemeral as to be practically useless.

MR. G. BUXTON BROWNE has been selected to deliver the Harveian Lectures before the Harveian Society of London, the first of which will be given on Thursday November 7th, the subject being "Twenty-five Years' Experience of Urinary Surgery."



## Notes on Current Topics.

### The Health of the King.

THE state of the health of His Majesty King Edward VII. has for months past been the subject of comment in certain American and Continental journals. Nearer home rumours of the most painful kind have been current for some time in commercial and social circles that have the reputation of being well-informed in political matters. The serious responsibility that rests upon journalism in approaching a question of vital interest, not only to the vast British Empire, but also to the world at large, might well account for the silence that has hitherto been preserved in English newspapers. That responsibility is not lessened, but many times multiplied, in the case of a medical journal. With a full sense of the difficulties and the delicacy of the situation, however, we feel that the time has arrived when a full statement of the facts relating to the illness from which His Majesty has recently been suffering should be laid before the nation. In view of the fact that a detailed account has been published of several surgical operations performed in rapid succession, we feel it is no longer possible to ignore the subject, however painful and pathetic the picture that it suggests. It is stated that papillomatous growths have on three occasions been removed from the left vocal cord, and that an immediate operation of another nature has since been rendered necessary. The anxiety and distress that these rumours must cause throughout the British Empire will be incalculable. It is probable that no English monarch has ever attained a securer place in the affection of his subjects than that which has deservedly fallen to the lot of our present King. Under these circumstances, therefore, it seems right and proper that the national anxiety should be at once met with a clear official announcement as to the truth or otherwise of these distressing reports.

### Trained Nurses for Irish Workhouses.

A FIERCE wordy war has been in progress for the past couple of weeks over the question of the qualifications which are required in trained nurses for Irish workhouses. It has been the outcome of, first, the Order of the Local Government Board of July 5th, and, secondly, the inaugural address delivered at the opening of the medical session of St. Vincent's Hospital by Dr. Cox, an abstract of which we publish in our columns to-day. The Local Government Board, as our readers know, have decided that a woman to be a trained nurse must have resided for not less than two years in a general clinical hospital. This condition meets with the approval of Dr. Cox, and of a large number of members of the medical profession who are well qualified to form an opinion on the point. It has, however, given rise to much indignation amongst the members of the staff of various county infirmaries. Many of these gentlemen consider that their infirmaries have reached so high a standard that they are well fitted to be recognised as suitable training grounds for nurses.

Dr. Thompson, of Omagh, and Dr. Laffan, of Cashel, have taken up this view very strongly, and have urged its correctness with considerable force in the daily papers. The subject is one pregnant with difficulties, and which admits of much truth on both sides. There is no doubt that there are some county infirmaries which are admirably suited for the training of nurses. There is equally little doubt that there are many others which are unsuitable. How is the distinction to be made? If the rule of the Local Government Board is altered it must be altered so as to include all hospitals having more than a certain number of beds, and will that bring about the greatest amount of good for the greatest number? We question it very greatly. The teaching capacity of a hospital is not merely a matter of the number of beds. There are other points of much greater importance. It may, of course, be said that the holding of a public examination would render it possible to reject all insufficiently trained nurses. But with such an opinion we cannot agree. An examination is an excellent test of the capacity of a candidate to answer the questions asked, but everybody knows how absolutely fallacious it is as a test of the fitness of the candidate to make use of the knowledge he or she possesses. It is only by carefully prescribing the manner in which the knowledge is obtained that any guarantee of suitability is possible. It is this which makes it so important to ensure that the training which nurses receive will be such that it will provide them not only with the requisite knowledge, but that it will provide them with this knowledge in the requisite way.

### Life Assurance for Women.

THE question of issuing policies of insurance on the lives of women is one of considerable interest, and presents problems of some complexity. If we take the general mortality returns it would seem that women, as a class, live longer than men, and this fact is explained by statisticians on the ground that they are less exposed to wear and tear than males, upon whom devolves the task of providing the means of existence. If, on the other hand, we take the returns of life insurance companies, which deal only with selected lives, we find that women who have taken out policies live shorter lives than men. This result is in flagrant contradiction with the general returns and with the statistics of companies which grant annuities for life, annuitants being proverbially long-lived. The inference to be drawn from these figures is that the medical examination of women requires special attention in order to eliminate certain risks inherent to the sex. It has been urged, not without reason, that the examination of women in view of life insurance ought to bear particularly on the pelvic organs, and in a paper on this subject published in *La Medecine Moderne*, Dr. Mahillon, of Brussels, urges that no examination of a woman for life insurance purposes is complete unless it comprises the investigation of

the pelvic organs. He admits, readily enough, that any such condition would have for effect to discourage women from contracting assurances, but he consoles himself with the reflection that in the absence of this special examination such assurances are best avoided. As society is at present constituted it is evident that women have less incentive to insure their lives than men, as is proved by the comparatively small number of women who have recourse to this form of thrift. The companies have therefore an interest in ascertaining the particular motive which induces a woman to solicit a life insurance. They would even be justified in exacting what is termed an insurable interest on the part of women, such, for instance, as the existence of annuities terminable with the life of the insured, otherwise the proposal may be the outcome of a speculation on the part of third parties who hope to benefit by the policy. The subject is one which merits special consideration. Not long since the Medical Sickness Society had to consider the admission of qualified women to the benefits of this excellent organisation and concluded to refuse such proposals in view of the absence of data which would enable the risks to be estimated. Obviously, during the child-bearing period, women run many risks from which men are exempt, and as this category of risks cannot well be excluded, it would be imprudent to insure them at the same rates as men. We are unable to state what is the attitude of other similar societies in respect of female candidates, but we hardly imagine that they accept these questionable risks without a compensatory increase in the premiums.

#### An Oxygen Fallacy.

WHEN Scheele first directed public attention to the remarkable properties of oxygen gas, which he called "vital air," imagination ran riot for a time, and the new gas was credited with the most extraordinary properties; indeed, it was confidently predicted that health and longevity were in future to be had for the asking, or, at any rate, for the paying. These sanguine views unfortunately proved to be fallacious, and for a long period oxygen, as a therapeutical agent, fell into complete discredit. Within the last twenty years or so the possibility of obtaining the gas at a moderate cost gave a fresh impetus to its use, and it is now very largely employed in diseases associated with respiratory failure. It has even been vaunted as a remedial agent in the treatment of chronic ulcers, and a special hospital has been founded for the purpose of carrying this somewhat costly treatment into effect. The latest freak is the treatment of consumption by ozonised air, which is being tried at that incongruous institution, the Oxygen Home, in Fitzroy Square. The patient, we gather, is placed in a cubicle supplied with ozonised air, purified by filtration through cotton wool and dried by passage over chloride of calcium. The initial error is the idea that consumptive patients suffer from defective oxygenisation, whereas the very contrary is the case. As a

matter of fact, these patients are suffering from true consumption; that is to say, over-combustion. The respiratory changes, measured by the output of carbonic acid, are in excess of the normal; indeed, this excess is present long before any lesions are perceptible by auscultation, and constitutes a means of diagnosing what has been termed a pre-tuberculous stage. Under these circumstances, it would be interesting to know on what scientific data the treatment is based, especially as it has long since been put to the test and found wanting.

#### Lunatics at Large.

THE object of the lunacy laws is to secure the sequestration of all persons whose mental condition renders them dangerous to the community. The records of the trials at the Central Criminal Court afford a tragic commentary on these laws, or, it may be, on the manner in which they are administered. On Wednesday of last week no less than four cases of murder, or attempted murder, terminated by a verdict of irresponsibility, the prisoners being ordered to be detained "until his Majesty's pleasure be known." In every instance there was a history which pointed to mental disturbance of a disquieting kind, yet in none was any step taken to place the subject under restraint, with the result that they were left at liberty until the homicidal tendency had manifested itself at the expense of innocent victims. The information at our disposal does not allow of our apportioning the blame, but blame there must be, in a sense, though the negligence may have been due to sheer ignorance of the terrible significance of apparently mild departures from mental health. In every instance witnesses testified to the fact that the accused had been for a variable period prior to committing the crime, "peculiar in his (or her) manner," yet it does not seem to have occurred to any of them that this peculiarity called for treatment. The most distressing feature of these cases is that no ready means suggests itself of detecting and restraining the victims of mental aberration from criminal acts; but this position is so unsatisfactory that it is impossible to acquiesce in it as unavoidable. There is, however, no present machinery by which these potential criminals can be recognised, and the necessary precautions taken, but their presence in our midst unquestionably adds another anxiety to existence.

#### Plague at the Cape.

THE proclamation of martial law in South Africa and the close censorship of the press that has been so long established suggests some anxiety as to what may be the actual facts as regards the plague. From the first appearance of that malady at the Cape it was apparent that the situation had become complicated by the addition of a most serious danger. From time to time fresh centres of infection have been reported in various parts of Cape Colony. A few days ago Dr. Kirton, plague officer at Port Elizabeth, succumbed to the disease. A Reuter's telegram has given the curt informa-

tion that additional plague regulations have been proclaimed in the Cape peninsula, and at all ports and coastal towns in Cape Colony. Reading between the lines of this information it may be assumed that the plague has attained dimensions which the Press censor, for reasons best known to himself, thinks it wise to withhold from the nation at home. As we have all along pointed out, when plague gets a foothold in a country that is badly provided from a sanitary point of view, then the course of the disease is likely to be lingering, widespread, and disastrous. The condition of the whole of South Africa from a health point of view is about as bad as it possibly could be, a fact that has been abundantly illustrated in the disease mortality of the British Army. It would be much better to announce officially the truth, the whole truth, and nothing but the truth with regard to the plague, and to take measures accordingly.

#### Small-pox in London.

THE epidemic of small-pox in London, so far from abating, has suddenly shown a serious increase. At the end of last week the returns of the Metropolitan Asylums Board showed a greater number of patients under treatment, namely, 201, than at any previous period of the outbreak. The existence of so many centres of infection spread broadcast over London points to a grave state of matters that must continue to demand the earnest attention of those responsible for the public health. Vaccination and re-vaccination have been widely resorted to in all districts, but more especially in the wealthier quarters of the town. There can be little doubt that the present invasion will serve a useful purpose in educating public opinion upon the value and necessity of vaccination. Should small-pox get established in some of the notoriously anti-vaccinationist districts, such as parts of Whitechapel and Shoreditch, the results will probably be of a disastrous nature. As matters stand at present, it almost looks as if the Nemesis of a great outbreak of this terrible malady were closely dogging the footsteps of the Government responsible for the creation of that bugbear of scientific preventive medicine, the "conscientious objector."

#### In View of the Election!

MR. GEORGE BROWN took advantage of the opportunity afforded him by last week's meeting at Newcastle-on-Tyne to reply to the charges brought against him by Dr. Glover at the meeting of the Direct Representatives at the Cheltenham meeting of the British Medical Association. A reply of some sort was indeed to be expected, since Mr. Brown was not likely to sit quietly under the imputation that he is not a fit and proper person to represent the profession on the General Medical Council. At Cheltenham, Dr. Glover, referring to the view urged in certain quarters that the General Medical Council should punish the members of the Obstetrical Society of London for granting certificates to midwives, observed that the Council had only one

punishment, viz., to remove the name from the *Register*. He asked whether the most advanced medical reformer, Mr. Brown himself, for example, would venture to make a definite proposal to that effect in the Council, a step he might have taken any time in the last five years, but had not done so. Now for Mr. Brown's reply. He told his audience at Newcastle that the charge almost took his breath away, because he had a sort of dim recollection of having made the very proposition in question. On November 29th, 1899, the whole of the afternoon was occupied by the members of the General Medical Council in discussing various motions standing in the name of Mr. George Brown, and among these were two that certainly raised the very point in question, because their purport was to adjudge guilty of infamous conduct in a professional respect any registered practitioner who takes part in any examination in the art of midwifery held by a Society that is not legally authorised to hold such examinations. Mr. Brown considers that Dr. Glover had forgotten this Wednesday afternoon. That may or may not be the case, but when Dr. Glover has recovered from his indisposition it will be interesting to hear what he has to say on the matter.

#### Lager Beer in Acute Vomiting.

VOMITING and nausea are symptoms which are met with in association with a large number of conditions, especially in connection with pregnancy and in disease of the pelvic organs and of the nervous system. To be sure, there is no lack of remedies for this distressing state, but, as is well known, iced champagne, sipped at short intervals, is a trustworthy and by no means repulsive remedy. But champagne, even of average quality, is not accessible to many persons, and, according to a correspondent, lager beer, especially that which is dark in colour, has a very decided effect in arresting vomiting. The effect is most marked in those who are not accustomed to alcoholic beverages in any form, and the soporific action enhances the local sedative action. The dose must be proportioned to the severity of the case, but three bottles appear to be as much as most sufferers will require, as can well be imagined, for this quantity in a person unaccustomed to drinking beer is certain to determine marked physiological effects.

#### Foreign Bodies in Food at Restaurants.

THAT the law is a somewhat capricious arbiter of the fate of suitors is proverbial. Some two or three years ago a visitor at a well-known London restaurant swallowed a needle in some spinach served in the course of a public dinner. After much litigation the case was decided in favour of the defendants, a decision that was clearly not calculated to augment the confidence of customers in the management of hotel and restaurant cooks, inasmuch as they were thereby relieved of responsibility for the presence of foreign bodies in their *cuisine*. A recent case, however, seems to have more or less traversed the former decision. A gentleman

broke off two artificial teeth and damaged a tooth-plate by biting a button that lay hidden in a beef-steak pie which he was eating in a Bishopsgate restaurant. The defendant caterers, Messrs. Lyons and Co., denied responsibility, and said plaintiff's teeth should have been able to eat ordinary food, which, apparently, they considered might be expected to contain pieces of bone and kindred subjects. That flimsy argument was brushed aside by the judge, who laid down the common-sense view that it was defendants' duty to see that the food which they supplied contained no hidden dangers alien to its character as described in the bill of fare. When a man ate a beefsteak pie he did not expect to find a piece of bone or a button from the coat of the man who made the pie. The plaintiff was awarded the value of a new set of teeth.

#### The London County Council and Soil Pipes.

ON the whole the work of the London County Council affords an excellent example to other municipal bodies throughout the kingdom. It has achieved great things in the way of beautifying the metropolis and of bettering the physical environment of Londoners. Like all other young and energetic bodies, however, the Council has its faults, some of which will take a good deal of living down. From a medical point of view attention may be drawn to a retrograde step in sanitary administration, to which Mr. Mark Judge recently alluded in the course of a public lecture. Until the present year, he stated, the bye-laws of the County Council provided that all soil pipes should be outside a building. That definite bye-law, which has been in force some years, has now been repealed, and with the approval of the Local Government Board, another has been substituted under the Metropolis Management Act, 1855. The latter runs: "A soil-pipe in connection with a new building or an existing building shall, whenever practicable, be situated outside such building." This change renders the position of soil-pipes permissive. It undermines one of the most wise and practical provisions ever enforced in the matter of house drainage. Mr. Judge aptly asks what would be the result of the words "whenever practicable" added to other important rules at present applied to the structural conditions of dwellings and so on. To allow soil-pipes to be fixed inside dwellings instead of outside is to set back the hands of the clock. Verily, *nemo omnibus horis sapit.*, not even the L.C.C.

#### Amendment of the Medical Acts.

DR. S. WOODCOCK, of Manchester, is a candidate for election to the General Medical Council, and it is of some interest to know that he is fully alive to the necessity of having an amendment of the Medical Acts under which it would be possible to punish a man for practising without being registered. At the present day they found men practising with impunity as long as they refrained from the assumption of medical titles. The General Medical Council has, he pointed out, no control over unregis-

tered people, but, nevertheless, they had practically abolished the unqualified assistant by getting at the assistant's principal, saying to him, "We shall punish you if you employ an unqualified man." Dr. Woodcock has the happy knack of being able to impress his hearers by apt illustrative examples, and he related a few days ago at an election meeting how an unqualified assistant was asked what he was going to do after the decision of the General Medical Council had been issued. The man said that he was going to continue in the practice of medicine without using a medical title, and was at the present moment doing a very good practice in Manchester. In the same city an unregistered practitioner who had been imprisoned for a criminal offence did so well subsequently in practice that he left £20,000 to a Welsh University. Dr. Woodcock's experience of what was to be expected of the House of Commons also furnishes food for reflection. He was talking to a member of Parliament about the prescribing chemist, and was promptly told that it was useless to attempt anything against such a person because so many of the members were in the habit of applying to prescribing druggists for a pick-me-up as they went down to the House. Dr. Woodcock's view that the time is ready for some reform is certainly acceptable to the members of the medical profession, but the real point of the whole subject is to what extent is this idea shared in by Parliament, for, after all, it is with Parliament that the question of the amendment of the Medical Acts rests for settlement.

#### The Irish Colleges.

It is not often that the governing bodies of the Irish Colleges receive the measure of praise that is their just due. The gentlemen who control the policy and conduct of these Irish institutions are actuated by the very highest motives, and they do not hesitate to put into practice the principles by which they profess to be guided. This may be somewhat high-flown language to use, but Mr. George Jackson, of Plymouth, speaking at Newcastle on October 26th, afforded an example of the truth of the above remarks. The medical profession at Plymouth has been much troubled of late by the activity of the medical aid associations and certain insurance companies. The difficulty that had to be met was how to put pressure on the medical advisers of these clubs and societies so as to induce them to relinquish their connection with them. As Mr. Jackson admitted, it was useless to complain to the General Medical Council, so recourse was had to laying the matter before the Colleges which had granted these medical men their licences, and the evidence of Mr. Jackson should certainly afford gratification to the friends of the Irish Colleges. It was found that the Irish Colleges were willing to take up the cases of those men who were connected with these medical aid societies and insurance associations, and they wrote to them and said that if they continued in that sort of action their diplomas would be withdrawn.

We regret that this dignified course of procedure by the Irish Colleges was not also followed by other medical corporations, but all honour is due to the authorities of the Irish bodies for lending a helping hand towards the assistance of their fellow-practitioners in Plymouth, and the sooner other bodies follow suit the sooner they will earn the gratitude of the medical profession.

#### The Improvement in the General Medical Council.

SPEAKING at Newcastle on Saturday last Mr. Horsley said that during the last four years the legal work of the Council had been completely reformed, and he was evidently in complete accord with his audience when he said that it was a matter for congratulation that the General Medical Council now had for its solicitor a gentleman who was deeply interested in his work, and very keen to follow out every point so that the Council should never again be committed to such an awful scandal as that connected with the late Mr. Hunter. Mr. Horsley's remarks on the financial reform necessary in the Council had, somewhat justly, a triumphant note in them, and it was a pity that Dr. MacAlister, of Cambridge, was not present to hear Mr. Horsley's comments on what he called the most extraordinary misunderstandings and misstatements made on behalf of the Council by their official spokesman, Dr. MacAlister. In the last four years it had been driven home to the members of the Council that there must be an amendment of the Medical Acts. In spite of these lines of improvement Mr. Horsley's opinion is that the only way to secure a new Medical Act is by first reforming the General Medical Council. If that could be effected by a reformed British Medical Association there would be the groundwork of a real campaign against quackery.

#### The Effect of Diet.

THE varying conditions induced in different species of animals by diet, especially in relation to susceptibility to tuberculosis, have been investigated by Woods Hutchinson, at the London Zoological Gardens. In the case of monkeys it was found that there was a very marked divergence between those on a vegetarian diet and those on a meat diet. Seventeen out of the thirty-five deaths among the vegetarian monkeys in the course of six months were from tuberculosis, but not a single death from this cause was noted in the ten deaths among the carnivorous monkeys. The trend of opinion and of clinical experience has been of late towards emphasizing the importance of a highly nitrogenous diet in the treatment of tuberculosis at sanatoria, and curiously enough this is quite in agreement with the experience of the keepers at the Zoo, who have come to the conclusion that if the anthropoid apes are not put upon a diet of animal food it is only possible to keep them alive for a short time. This effect of food only partly explains the divergences noted in the susceptibility

to tuberculosis of the several species of animals, for certain of the herbivora have almost as complete an immunity as the carnivora. It is considered, and in our opinion rightly so, that the method of life of the carnivora, involving as it does a higher degree of activity, had something to do with this relative immunity. It was apparently a matter of vigour and endurance in the resistant powers rather than of race, diet, or exposure to infection, as these powers were usually higher in flesh eaters than in vegetable eaters.

#### The Neanderthal Skull.

ONE of the great landmarks in the study of primitive man has hitherto always been the extraordinary skull found in the Neanderthal cave. In spite of the attractiveness of the theories that have been founded upon the internal evidence of that famous relic there has always existed a lingering suspicion that the chain of scientific—that is, logical—proof was insecure. Skulls of somewhat similar construction are not infrequently found among existing individuals of low and presumably reversionary type. Who is to say that a prehistoric idiot has not slept his last sleep in that ancient cave, where his skull has been preserved by the capricious hand of Nature to puzzle far-off generations of scientists? If the skull came from a nation of similar type it would be reasonable to suppose that ere now companion skulls would have been unearthed. That has not happened, however, and the Neanderthal skull remains unique. Professor Virchow has dealt with these points in an address at the recent Congress of Anthropologists in Berlin. He insisted that it is impossible to infer from a single individual what a whole race may have been, and furthermore, that the conclusions drawn from the examination of a few skulls are misleading. If this declaration deprive popular lecturers of their Neanderthal skull it will have taken away one of their most valued possessions. However, they may take heart from the reflection that all we know of many extinct mammals is, say, an under-jaw or a thigh bone. The famous *Archæopteryx* skeleton, again, is a single representative of the transition form between reptile and birds.

#### PERSONAL.

DR. MACKENZIE, of Linlithgow, was thrown from his horse on Thursday last, and sustained serious injury to his head.

DR. LAMBE ATTEHILL has been elected President of the Royal Academy of Medicine for the ensuing session, the opening meeting of which will be held on Friday next.

DR. J. HALLIDAY CROOK, Physician to the Edinburgh Royal Infirmary, has been elected to the Presidency of the Royal College of Surgeons, Edinburgh, for the ensuing year.

MR. E. TREACHER COLLINS, F.R.C.S., has been elected to the newly-created post of Ophthalmic Surgeon to Charing Cross Hospital and Lecturer on Ophthalmology in the Medical School.

DR. JUDSON S. BURY, of Manchester, will deliver the Bradshaw Lecture before the Royal College of Physicians of London on November 5th on "Prognosis in Relation to Disease of the Nervous System."

MR. A. PEARCE GOULD is to deliver the Lettsomian Lectures before the Medical Society on London on February 17th, March 3rd and 17th next, on the subject of "Certain Diseases of the Blood Vessels."

SIR JOSEPH DIMSDALE, the Lord Mayor Elect, has promised to preside at a meeting to be held at the Mansion House in January next in aid of the appeal on behalf of Guy's Hospital for further public support.

MR. ALBAN DORAN, F.R.C.S., will be chief editor of the *New International Journal of Obstetrics and Gynaecology*, which is expected to appear in January. Messrs. Bailliere, Tindall, and Co. will be the publishers.

THE marriage of Surgeon Lieut.-Colonel Ralph Gooding, M.D., took place last week during his mayoralty of Greenwich, to Miss Laura Frances Baillie-Hamilton, youngest daughter of the late Admiral and Lady Harriet Baillie-Hamilton. Dr. Gooding's term of office expires on November 9th.

## Scotland.

[FROM OUR OWN CORRESPONDENT.]

GENERAL COUNCIL OF THE UNIVERSITY OF EDINBURGH.—Though this is the only body through which the greater number of its graduates can make their voices heard in University management, the meetings are not, as a rule, attended by many medical men. At the last statutory meeting, however, several topics of medical interest came up, and there was an unusually full attendance of medical graduates. A motion was tabled by Dr. R. J. A. Berry requesting the University Court to inquire into the feasibility of reorganising the medical curriculum on the lines suggested by the Pathological Club of Edinburgh. A certain amount of attention has already been directed to Dr. Berry's scheme an account of which has appeared in one of the Edinburgh medical journals. The principal changes proposed are the division of the academic year into three sessions of three months each, a diminution in the amount of time devoted to preliminary scientific subjects, with a corresponding increase in the time available for practical work. The student would no longer be compelled to take surgery in his second year, and would not be allowed to work in the hospital until after he had passed his second professional. He would no longer be permitted to take art classes in new subjects until he passed the previous professional examination. Into the details of the scheme it is impossible to enter here; suffice it to say that, while it reads well on paper, and would certainly be an enormous advance on the present arrangements, it is doubtful whether the University authorities will yield to such a sweeping scheme of reform. As it is the medical faculty has turned a rather unsympathetic ear to the report of the Medical Class Hours Commission—a body composed both of teachers and students, which went very fully into the question of conflicting class hours, and proposed certain alterations with a view to remedying these defects. Dr. Berry's motion was not carried in the exact form proposed, but a technical alteration was made so that it might be remitted to the business committee of the Council. The second motion of medical interest was one by Dr. E. Greville for returns of the number of hours spent by each professor in teaching his practical classes; the number of hours so spent by assistants; the amount of fees paid by the student for such practical classes. The mover of the motion has during the past summer issued

several rather polemic tracts dealing with the appointment of professors' assistants, and by his speech in support of the motion alienated many who would have voted with him. Many felt that the motion itself was desirable, but abstained from voting rather than seem to endorse the rather personal character of the speech introducing it. The motion was not carried.

THE CARNEGIE TRUST.—The joint reports of the Business and Finance Committees presented at this meeting of the General Council dealt with the Carnegie Trust and the decrease of students at Edinburgh. Speaking of the former, the reports discuss the claims of the various departments for financial assistance in teaching and equipment. It recommends that the Council represent to the University Court that the following are the clamant needs of the University: (1) The development of the work of the University in connection with the teaching of modern languages. (2) The strengthening of the teaching staff in the medical faculty. (3) The provision of suitably equipped laboratories for the instruction of students in all graduation subjects for which practical work is required. (4) The establishment of research laboratories. (5) The improvement of the library. The second, and less important, half of Mr. Carnegie's gift is devoted to the payment of fees. Contrary to the expectation of some who claimed to have an intimate acquaintance with the working of the scheme the full amount of fees claimed has been paid in almost every case, and this has often amounted to upwards of £20. Matriculation, hospital, and examination fees are not paid. The number of applicants seems to have been a little over 3,000, and the Trust is now busy with late applications. It is generally supposed that the first year's work is to be held as of an experimental nature, and no doubt changes will be enforced as occasion may demand, but it is impossible to withhold a tribute of admiration from all those concerned in the management of the Trust for the speedy way in which they have enabled the students of Scotland to participate in its benefits.

### THE GENERAL MEDICAL COUNCIL ELECTION, 1901.

MR. GEORGE BROWN'S ADDRESS TO THE REGISTERED PRACTITIONERS OF ENGLAND AND WALES.

FELLOW PRACTITIONERS,—As the term for which you elected Dr. Glover and myself in 1896 to represent you in the General Medical Council will expire on January 1st next, you will shortly be called upon to fill the seats which will thus become vacant.

I beg to inform you that it is my intention to offer myself for re-election, and I venture to hope that my efforts to serve your interests during the four and a half years I have had the honour to represent you will ensure me a renewal of your confidence.

It will be in the recollection of many of you that at the last election I pledged myself, if successful, to do my utmost to carry out a definite line of action in regard to five questions of great importance as affecting the wellbeing of the profession. Respecting these, it may be convenient if I as briefly as possible report progress.

1st.—Amendment of the Medical Acts with a view to the suppression of Unqualified Practice.

As yet it has been impossible to persuade the Council to take action in favour thereof, but as some of the most powerful opponents of medical reform have, during the last year or two, ceased to be members of the Council, and their seats are now occupied by others whose views are more in harmony with those held by the bulk of the profession, I am not without hope that medical reform will be regarded with more favour in the future, although some outside pressure may be necessary before the Council takes any practical steps to promote a Bill to amend the Medical Acts in the direction indicated.

2nd.—To prevent sick clubs and dispensaries whose agents canvass for patients from obtaining the services of registered practitioners.

It is a great satisfaction to me to know that I have

assisted in passing a resolution expressing the disapproval of the Council with those practitioners who associate themselves with clubs whose agents systematically canvass for patients. This resolution is a step in the right direction, but as the expression of a pious opinion it will, I fear, be of little use. The degrading practice can only be suppressed by dealing with it in the same manner as offences which are regarded as infamous in a professional respect. I shall always insist, as I have in the past, that the absence of a wage-limit is likely to lead to the abuse of clubs and dispensaries, as well as to friction and contentions among neighbouring practitioners.

### 3rd.—To oppose the Bill for the Registration of Midwives.

Through the action initiated by me at the May session, 1897, notwithstanding that the Council had previously in very decided language, to use the late Sir Richard Quin's own words, declined to interfere with the proposed legislation respecting the practice of midwives, the Council appointed a special committee to consider the proposed measure. As a result the Lord President of the Privy Council was informed that the Council "would earnestly deprecate its passing into law." Happily, in consequence of the opposition thus raised, the mischievous Bill did not receive the sanction of Parliament, and I have no fear that it ever will become law if the profession as a whole continues to exercise the vigilance and activity in opposing the measure it has hitherto done. Much will depend upon the votes recorded in this election, and you may rely upon me that my opposition to legalising midwives as independent practitioners will be as keen as ever, and I should like both midwives and all unqualified practitioners made legally responsible for any damage they may cause to mother or child or any other person. I am, however, in favour of legislation to ensure the better education and registration of obstetric and other nurses to act under the direct supervision of medical practitioners.

### 4th.—The raising of the standard of medical education.

In accordance with my pledges, I have worked in harmony with those members of the Council who are in favour of raising the standard of education, and it is satisfactory to report that during the last year or two regulations have been adopted lengthening the course of professional study and raising the standard of preliminary examinations. It is to be regretted that the Royal College of Physicians and the Royal College of Surgeons of England appear disposed to dispute the authority of the Council in regard to this matter. Although I am a member of the College of Surgeons I feel that in all questions relating to medical education the fiat of the Medical Council should be absolute, and as long as I continue to be a member of that body my action will be guided by a sincere wish to support its authority. Unless the Council's authority be maintained, medical education will soon become chaotic.

### 5.—Increased Direct Representation.

On two occasions I have proposed motions calling upon the Council to make application to the Privy Council to obtain an additional Direct Representative for England and Wales, as provided for in the Medical Act of 1886, but I regret to say that on each occasion the proposition was rejected by a large majority. If I continue to represent you on the Council I shall again press this question upon the members, but I fear nothing will be accomplished in that direction unless a direct appeal to Parliament be made. I shall do my utmost, both inside and outside the Council, to assist those who consider that their Representatives on it should be elected by the graduates of the universities and the members of the corporations, and not solely by the Senates and Councils respectively.

It is a satisfaction to me to report that during my term of office I have taken an active part in bringing about the promulgation of new regulations respecting the employment of unqualified assistants which have done more to protect the public against unqualified practice and to elevate the profession than any other

measure adopted by the Council since the profession has had the privilege of sending direct representatives to the Council.

There are other points I would have desired to mention in this address, but must deal with them at the public meetings. I would therefore conclude by thanking you for the generous consideration shown towards me during my term of office, and by giving you the assurance that should you honour me by re-electing me as one of your representatives I shall, as in the past, do all in my power to serve your interests and to uphold the honour and dignity as well as the interests of our profession.

I remain, Fellow Practitioners,  
Your obedient servant,

GEORGE BROWN.

6, Gibson Square, London, N., October, 1901.

MR. GEORGE JACKSON'S ADDRESS TO THE REGISTERED PRACTITIONERS OF ENGLAND AND WALES.

Ladies and Gentlemen,—Having been invited by the Incorporated Medical Practitioners' Association, in conjunction with Mr. George Brown, to become a candidate as a direct representative on the General Medical Council, I have acceded to their request, and am encouraged to do so by the fact that I obtained 4,082 votes at the last election, although very late in the field.

On the last occasion, omitting a bye-election caused by the resignation of Dr. Bentoul, the contest turned principally on the question of the registration of midwives, the votes in favour of it being only 8,443 as against 28,040.

I am now, as then, opposed to the registration of midwives, the creation of an inferior order of practitioners. The only way to settle this vexed question is by the registration of all nurses, who will be obliged to act under the direct control of duly-qualified medical practitioners.

The objects which should engage the attention of the General Medical Council in the immediate future, should be in my opinion:—

1. The reform of the Medical Acts, so as to provide for direct representation of the medical profession in every case except the Crown nominees.

2. Raising the standard of the entrance examinations, and limiting the age of entrance so as not to be under seventeen years.

3. The one-portal system of entrance to be secured by forming a Board of Examiners, composed of delegates from the present examining bodies.

4. Such an alteration of the Acts which will give the Council power to suppress quacks, &c., who practise medicine and surgery under various forms of colourable pretences.

5. A more definite pronouncement against medical men acting as medical advisers to clubs and insurance societies whose agents tout for members.

For the information of those to whom I am unknown personally I may state that I have taken an active part in medical politics for more than twenty years.

In conjunction with Mr. Reginald Harrison I set on foot some twenty years ago a movement which had for its object the voting by voting papers for the election of members of the Council of the Royal College of Surgeons, which was successful.

About fifteen to sixteen years ago I endeavoured to establish locally a medical sick assurance society, and thus helped to prepare the way for the Society which at present exists, and does such good work.

In 1895 I was President of the Incorporated Medical Practitioners' Association, and founded the Devon and Cornwall local branch of the same, which has done good work in checking irregular practice and the like.

Last year I was a delegate of the Plymouth Medical Society to the medical organisation meeting at Manchester, and was appointed a member of the committee which has had a great deal to do with the reform of the British Medical Association.

I have assisted in the work of establishing the Three Towns (Plymouth, Devonport, and Stonehouse) Provident Dispensary in conjunction with the local branch of the Incorporated Medical Practitioners' Association,

which works on the principle of a wage-limit, the management being in the hands of the members of the staff.

Asking the favour of your vote and interest,  
I remain,

Your obedient servant,  
GEORGE JACKSON,

F.R.C.S. Eng., Ex-President and Vice-President of the Incorporated Medical Practitioners' Association and of the Devon and Cornwall Branch of the same, and Ex-President of the Plymouth Medical Society.

10, Portland Villas, Plymouth, October, 1901.

ADDRESS BY CHAS. HAYWARD, M.D., D.P.H., C.D.S.D.,  
&c. (Barrister-at-Law).

As one who believes it to be essential that the General Medical Council should undergo some radical alterations and improvements, and who trusts that he is to a considerable extent qualified to assist in the proper carrying out of these modifications, I am coming forward as a candidate at the approaching election.

The foundation of my claims is, that I believe that the General Medical Council should be essentially concerned with the welfare and interests of the general medical profession and the safety of the public, and not, as at present, only with trying to reconcile the various selfish interests and jealousies of the different corporations and licensing bodies.

The constitution, procedure, and finances of the Council require thorough revision, and the members must directly represent the profession, not the restricted councils of each corporation.

The present unfair treatment suffered by our direct representatives must be met by sending resolute men who will not flinch from asserting the wishes and interests of the general profession, no matter how bitterly the vested interests oppose; and in some instances this opposition has overstepped the limits of mere bullying and become absolutely illegal.

It is especially in such circumstances, and also in the necessary amendments to the Medical Act and other legislation, that I hope my qualification of barrister-at-law may be of especial service to my fellow-practitioners; and as I now am, and have been for over fifteen years, engaged in general medical practice, I trust that the profession will recognise that it would be to their interest to avail themselves of the services which I now place at their disposal.

Grove Street, Liverpool, October 27th, 1901.

### Correspondence.

[We do not hold ourselves responsible for the opinions of our correspondents.]

#### THE BACTERIOLOGICAL TEST.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR.—Mr. Sers is disappointed that I did not respond to his last letter. His letter of October 2nd so wandered from the point at issue between you, Mr. Editor, and myself that I considered it necessary to restate my original argument, and this you very courteously permitted me to do in your issue of October 9th. I have not the slightest objection to reply to any arguments which Mr. Sers chooses to set forth on the whole question of vivisection, but I cannot waste my time nor trespass on your hospitality by dealing at length with all Mr. Sers' rather involved sentences and his somewhat irrelevant arguments. I like to deal with one thing at a time, and I asked in my last letter how did the biological test help in the case of my relative whose story I told at the beginning of this controversy. As Mr. Sers has not answered this reiterated question the matter goes by default as judgment for me. I say it did not help at all. I have no contempt, as your correspondent seems to imply, for the science of bacteriology; all I maintain is that if trusted implicitly as a means of diagnosing a difficult or obscure case it is exceedingly liable to lead us astray, and I think most bacteriologists would admit this. If bacteriology involved no cruelty to animals I should become an ardent student of the science for its

own sake, but I should be exceedingly cautious how I let it influence my dealings with my patients. I am no fanatic, require no coaxing "to turn from the error of my ways," as your correspondent suggests that I should, and am quite open to conviction on any subject Mr. Sers may introduce, but I am not anxious to discuss the very technical and wide subject of vivisection in relation to medicine and surgery with a gentleman who boasts that he "knows little or nothing about it." I have studied the question for twenty years very closely, and am well aware of the difficulties involved in its discussion, and I am sure your very courteous correspondent will pardon me for saying that the relation of animal experimentation to medical science is not to be discussed like Mark Twain's opinions on chemical science, "with an unbiased mind because he knew nothing whatever about it."

I am, Sir, yours truly,

EDWARD BERDOE.

London, October 25th, 1901.

#### COUNTER-PRESCRIBING BY CHEMISTS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR.—My attention having been directed to an article in your valuable journal of October 23rd under the heading "Casting out the Mote," I think it but fair to myself both as president of the Pharmaceutical Society and as a pharmacist, and also on behalf of my brother pharmacists, to say that I have as strongly condemned the practice of counter-prescribing by the pharmaceutical chemist, as I have, and do, the compounding of prescriptions by unqualified and incompetent persons; both at our Council and other meetings. I have strongly deprecated this practice (if it exists). I consider the moment we pass the line of merely recommending a certain nostrum for some minor ailment, such as a cough, &c., and attempt to diagnose the case and prescribe for such case, then I most emphatically say we as chemists outstep the limits laid down by the law, and exceed our duty and the privileges conferred on us by our diploma; but surely you do not infer that the chemist is not to recommend such nostrums, the ingredients of which he is quite familiar with and cognisant of their therapeutical effects. I think it is more the business of the pharmaceutical chemist who has served an apprenticeship and passed his examination to put up these articles than the wholesale man, who in some or most cases knows little, if anything, of the properties of the drugs he is handling, and I maintain that the chemist thus acting differs very materially from counter-prescribing.

I am very pleased to say that in no city of the kingdom is the practice of counter-prescribing by the chemist practised less than in Dublin; consequently, then, the pharmaceutical chemist enjoys the confidence and esteem of the medical profession, and it is my fervent wish that such relations may long continue. Trusting you will excuse my trespassing thus far on your valuable space,

I am, Sir, yours truly,

G. D. BEGGS, Pres. Ph. Society, Ireland.

Dalkey Medical Hall, Oct. 25th, 1901.

### Medical News.

#### The New War Council.

THE following statement has been issued by the War Office:—

1. The Secretary of State has directed that in future the War Office Council shall be constituted as follows:—

President—

The Secretary of State for War.

Members—

The Commander-in-Chief.

The Parliamentary Under-Secretary of State.

The Permanent Under-Secretary of State.

The Financial Secretary.

The Quartermaster-General.

The Inspector-General of Fortifications.



The Director-General of Ordnance,  
The Adjutant-General.

The Director-General of Mobilisation and Military Intelligence.

The Director-General Army Medical Department (for medical and sanitary questions).

The Secretary of the Council.

And such other members of the Staff of the War Office as may be specially summoned from time to time.

2. In the absence of the Secretary of State the Commander-in-Chief will act as President.

3. The Council will meet on Mondays, unless otherwise ordered, at twelve o'clock in the Secretary of State's room.

4. The Council will discuss such matters as may be referred to it by the Secretary of State and any question brought before it by individual members. In order that a *precis* may be prepared notice of the matters for discussion, together with the office papers on the subject, should reach the secretary not later than the Wednesday evening before each meeting.

5. Records of the proceedings will be kept and copies will be supplied to each member.

In addition to the foregoing there is to be a Permanent Executive Committee of the War Office, under the presidency of the Permanent Under-Secretary of State, or in his absence of the Assistant Under-Secretary of State, with certain military and other officials, and the Deputy-Director-General, Army Medical Department, or an officer selected by the Director-General, as members; and the present *Army Board*, of which the Director-General of the Army Medical Service is constituted a member, will be continued.

#### Contract Medical Attendance at Burton-on-Trent.

The club doctors of the Burton-on-Trent District are agitating for a readjustment of their remuneration, more particularly in respect of the juvenile members, who, it is contended, should pay four shillings per head per annum. The clubs are determined to resist this by no means exorbitant demand, and have decided, it is reported, to establish a medical aid association, and to import four practitioners to take over all the club work. We fancy, however, that they will not find this "undertaking" as easy as they imagine. If the practitioners will stick to their guns we do not doubt that ultimately the clubs will recognise the validity of the claims and acquiesce in the inevitable.

#### A Medical Man Committed for Trial.

AFTER a hearing extending over four days, Dr. William Tyndale Watson, Medical Officer of Tottenham, who has resided there nearly forty years, was yesterday committed for trial on charges of improper behaviour to girls who were sent to his house for medicine.

#### St. George's Hospital Medical School.

THE Lord Chief Justice (Lord Alverstone) presided at the annual distribution of prizes at this school on Monday last, when the following were presented:—Mr. W. Byam, the H. C. Johnson Prize in Anatomy, and Prize for Proficiency in Anatomy, Physiology, and Physiological Chemistry; Mr. S. H. Watson, Certificate of Honour in Anatomy; M. A. Manuel, the Pollock Prize in Physiology; Mr. C. M. Henley, Sir Charles Clarke's Prize; Mr. W. B. Swete-Evans, Sir B. Brodie's Clinical Prize in Surgery; Mr. A. Jex-Blake, B. A., Brackenbury Prize in Medicine, Treasurer's Prize, and Thompson Medal; Mr. T. C. English, the William Brown £100 Exhibition, and the Webb Prize in Bacteriology; Mr. A. B. Coomber, an Entrance Scholarship in Arts of the value of £50; Mr. H. E. S. Collier, an Entrance Scholarship in Arts of the value of £150; Mr. T. Drysdale, B.A., an Entrance Scholarship in Science of the value of £85.

#### Royal Academy of Medicine in Ireland.

At the annual general meeting held in the Royal College of Physicians on Friday last, 25th inst., the report for last session was adopted and officers elected for the present session. It was announced that invitations had been received to the first Egyptian Medical Congress, to be held at Cairo in December, 1902, and to the fourteenth International Medical Congress, to be held at

Cairo in April, 1903. Fellows wishing to attend these Congresses are requested to communicate with the Secretary for Foreign Correspondence. The following officers were elected for the ensuing session, 1901-2:—President, Lombe Atthill; General Secretary, John B. Story; Secretary for Foreign Correspondence, Sir J. W. Moore. Medical Section: President, Sir C. Nixon; H. T. Bewley, James Craig, H. C. Drury, E. A. Hayes, T. P. Kirkpatrick, Conolly Norman, J. O'Carroll, G. P. Acocke, R. Travers Smith, W. Langford Symes. Surgical Section: President, Thomas Mylos; Arthur Chance, Henry Croly, F. Conway Dwyer, T. E. Gordon, G. Jamieson Johnston, John Lentsigne, H. E. Swauzy, E. H. Taylor, W. Taylor, R. H. Woods. Obstetrical Section: President, W. J. Smyly; E. A. Flynn, J. H. Glenn, A. J. Horne, H. Jellett, F. W. Kidd, J. L. Lane, A. V. Macan, A. J. Smith, E. Hastings Tweedy, T. H. Wilson. Pathological Section.—President, E. J. M'Weeney; A. H. Benson, J. B. Coleman, F. C. Crawley, W. R. Dawson, H. C. Earl, A. C. O'Sullivan, A. B. Parsons, D. Rambaut, J. A. Scott, A. H. White. Section of Anatomy and Physiology.—President, D. J. Cunningham; A. Birmingham, D. J. Coffey, A. Fraser, J. A. Scott, W. Taylor, W. H. Thompson. Section of State Medicine.—President, Ninian M'I. Falkiner; Sir C. Cameron, C.B., W. R. Dawson, F. C. Martley, H. Oulton, D. Rambaut, J. M. Redmond.

### Pass Lists.

#### Edinburgh University.

THE following candidates have been successful in passing the final professional examination for degrees in Medicine and Surgery:—Old Regulations: M.B.C.M.: Clarence Granville Hey, Arthur Hutton M'Shine, Albert Cormac Peterson, Percy Wilfred Shepherd. New Regulations: M.B.C.M.: Arthur John Brook, Alfred Brown, John Webster Duffus, John Munro Dupont, Lucius Austen Holcroft, John Jamieson, Ernest Winbolt Lewis, Harriet M'Cloughry, John Bryce M'Cutcheon, Lionel Alexander MacMunn, Kenneth Duncan Cameron Macrae, Antoine Felix Gaston Maason, Robert Murray, Peterwald Pattison, George Archibald Park Ross, Richard Rutherford, Charles William Somerville, George William Smith, William Casswell Spooner, George Henry Steven, George Cecil Strathairn, James Paget Thorne, Noel Nathaniel Wade, Douglas Larmer Wall, Harold Edger Wareham, Philip Weatherbe.

#### The Royal University of Ireland.

THE Examiners have recommended that the following candidates be adjudged to have passed the under-mentioned examinations respectively: M.B., B.Ch., B.A.O. Degrees Examination:—

Upper Pass.—\*John H. Ferris, Robert W. Fisher, \*John H. Gill, Patrick Heffernan, B.A., \*Michael J. Laffan, B.A., Alexander McCloy, Hugh M. McCrea, \*John E. MacIlwaine, \*John S. F. Weir, and John A. Williams.

Candidates marked with an asterisk may present themselves for the further Examination for Honours.

Pass.—John M. Aherne, William J. Bannister, Frederick C. Bullen, Robert H. Caughey, B.A., William J. B. Fergus, Frederick Garland, John Knox, Richard McCandless, Daniel S. A. O'Keefe, Henry E. S. Richards, William Rodgers, M.A., Henry Ross, William A. Sandys, and Robert A. Stewart.

M.D. Degree Examination.—William J. Dargan, M.B., B.Ch., B.A.O., John Reid, B.A., M.B., B.Ch., B.A.O.

M.Ch. Degree Examination.—Charles Cooper, M.D.

M.A.O. Degree Examination.—Charles Cooper, M.D.

Conjoint Examinations in Ireland by the Royal College of Physicians and the Royal College of Surgeons.

The following candidates have passed the Second Professional (Old Regulations) Examination as under-noted:—(a) In all subjects, M. W. Kelly; (b) completed the examination, T. M. Allen, F. X. Costello, D. E. Crobbie, Miss S. F. Dickson, Jas. Nash, E. O'Grady, M. O'Keefe, and C. R. Richardson. The names of the candidates who passed Part I. under the New Regulations are not published till they complete Part II.

## Notices to Correspondents, Short Letters, &c.

**CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

**ORIGINAL ARTICLES** or **LETTERS** intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication, but as evidence of identity.

**REPRINTS.**—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the publisher or printer before the type has been distributed. This should be done when returning corrected proofs.

**MR. H. E. (London).**—The errors of which you complain were referred to in our notice of the work soon after its appearance, and no useful purpose would be served by dishing them up afresh. They are only minor blemishes, and do not detract materially from the value of the treatise.

**MR. W. S.**—We prefer to let the matter drop.

### THE ANDERSON FUND.

The committee formed to appeal for aid for the widow and two sons of the late Mr. R. B. Anderson, F.R.C.S., beg to announce the following additional list of subscriptions from July 26th to October 22nd. The total amount now subscribed is 73 guineas.

	£	s.	d.		£	s.	d.
Edmund Owen, Esq.	2	2	0	K. W. M....	1	1	0
Reg. Gilbert Esq.	2	0	0	G. B. Toye, Esq.	1	0	0
G. Durnford Thomas, Esq.	2	2	0	A. H. Dodd, Esq.	1	1	0
Dr. F. de Havilland Hall	2	2	0	Dr. Collier	2	2	0
Dr. Connel	1	0	0	Dr. W. J. Branch	1	0	0
H. C. M.	0	5	0	G. Jackson, Esq.	1	1	0
W. E. Burchell Esq.	1	1	0	E. J. Page Smith, Esq.	1	1	0
Dr. Edmund Frost	2	2	0	Capt. W. E. Battye	1	1	0
Dr. B. Baldine	1	1	0				
W. F. Brook, Esq.	1	1	0				
					£24	3	0

Donations for "The late R. B. Anderson Fund" should be sent and made payable to the Manager, Union Bank of London, Chancery Lane, London. As it is proposed to close the fund at an early date, intending subscribers are requested to send in their donations without delay.

THE EARL OF STAMFORD, Chairman.  
TIMOTHY HOLMES, Esq., F.R.C.S., Hon. Treasurer.  
WALTER MONNINGTON, Esq., 7, Fig Tree Court, Temple, E.C., Hon. Sec.

**J. W. D.**—(1) Yes. *Vide* Colten, on "Cancer of the Uterus," p. 658, *et seq.* (Kilmington, 1900). (2) We can find no reference of such ever having been done. It has been suggested to *inoculate* the serum of animals which have been previously inoculated with cancer "juice." *Vide* B. M. J. Epitome, Vol. i, 96, 51, and Vol. ii., 95, 60.

**DR. G. H. EVANS (San Francisco).**—Letter to hand will be considered.

**MR. G. C. E.** is thanked for his MS., which is, however, hardly suitable for our columns.

**ERRATUM.**—In our review of Dr. Macnaughton Jones's "Practical Points in Gynecology," September 18th, page 322, the translation of Schultze's "Displacements of the Uterus," it should have been stated, was due to Dr. J. J. Macan and not to Dr. Moon.

## Meetings of the Societies.

### ENGLAND.

WEDNESDAY, OCT. 30TH.

**BRITISH BALNEOLOGICAL AND CLIMATOLOGICAL SOCIETY** (20, Hanover Square, W.).—8.30 p.m. Address by the incoming President, Dr. Douglas Kerr. Dr. Houchin on Aix Treatment of Syphilis in London.

THURSDAY, OCT. 31ST.

**NEUROLOGICAL SOCIETY OF LONDON** (11, Chandos Street, Cavendish Square, W.).—8.30 p.m. Cases will be shown by Drs. Ferrier, Mutchison, Head, and Muskens.

FRIDAY, NOV. 1ST.

**LARYNGOLOGICAL SOCIETY OF LONDON** (20, Hanover Square).—5 p.m. (Cases will be shown by Mr. Spencer, Dr. Donnan, Dr. St. Clair Thomson, Dr. Tilley, Mr. Westmacott, Dr. St. George Reid, Mr. Laka, and Mr. Waggett).

**WEST KENT MEDICO-CHIRURGICAL SOCIETY** (Royal Kent Dispensary, Greenwich Road, S.E.).—8.45 p.m. Mr. G. Chisholm Williams on High Frequency Electrical Currents in the Treatment of Certain Diseases.

**WEST LONDON MEDICO-CHIRURGICAL SOCIETY** (West London Hospital, Hammersmith Road, W.).—8.30 p.m.

THURSDAY, NOV. 7TH.

**HARVEIAN SOCIETY OF LONDON.**—8.30 p.m. First Harveian Lecture. Mr. Buckston Brown's Twenty-five Years' Experience of Urinary Surgery in England.

### IRELAND.

WEDNESDAY, OCT. 30TH.

Inaugural Address at Jervis Street Hospital. Opening of Session.

Supplementary Conjoint Preliminary Examination Royal Colleges of Physicians and Surgeons. 4.30 p.m.

FRIDAY, NOV. 1ST.

Monthly Meeting Royal College of Physicians.  
Royal Academy of Medicine, Section of Pathology, Royal College of Surgeons, 8 p.m.

MONDAY, NOV. 4.

Royal College of Surgeons Fellowship Examinations and Examination for L.K.C.S. (registered practitioners) commence.

## Appointments.

**BIRD, ARTHUR CYRIL, M.R.C.S. Eng., L.R.C.P. Lond.,** Surgeon to the Victoria Cottage Hospital, Sidmouth, Devon.

**BROWLEE, ALEX., L.R.C.P. and S.E., L.D.S. Edin.,** Senior House Surgeon to the Ingham Infirmary, South Shields.

**BYGOTT, ALBERT HENRY, M.B. Lond.,** District Medical Officer for the Dorset and Bordesley Districts of the Aston Urban.

**CUTFIELD, A., M.R.C.S., L.S.A.,** Medical Officer for the Urban District of Ross.

**FORSTH A. F., M.B., C.M. Aberd.,** District Medical Officer for Kea and West Kenwyn by the Truro Board of Guardians.

**JACKSON, D., M.D., L.F.P.S. Glasg.,** Medical Officer for the Urban District of Hexham.

**LAMB, J. M. A., L.S.A.,** District Medical Officer of the Poole Union.

**SUTCLIFFE, W., M.R.C.S., L.R.C.P. Lond.,** Medical Officer of the West Bromwich No. 3 District.

**SYKES, WALTER, L.R.C.P.,** L.R.C.S. Eng., L.F.P. and S. Glasg., Junior House Surgeon to the Birmingham and Midland Eye Hospital.

**WILLETT, GEORGE GILMORE DRAKE, M.R.C.S., L.S.A.,** Medical Officer for the Marksbury District of the Keynsham Union.

## Vacancies.

**Bracebridge Asylum, near Lincoln.**—Junior Assistant Medical Officer. Salary £125 per annum, with furnished apartments, board, attendance, &c. Applications to W. T. Page, jun., 5 and 6, Bank Street, Lincoln.

**Essex County Asylum, Brentwood.**—Fourth Assistant Medical Officer. Age not over twenty-five years. Salary £150 per annum, with board, &c. Apply to the Medical Superintendent, Glasgow University.—Additional Examinations in Medicine and Science, with special reference to Chemistry, Materia Medica, Zoology, Practice of Medicine and Surgery. Particulars as to dates, emolument, &c., on reference to our advertising columns.

**India.**—Assistants on Tea Plantation. Healthy climate. Salary commencing at £300, with free bungalow. Must be English, Scotch, or Irish, and unmarried. Apply Mr. G. B. Stocker, 22, Craven Street, Strand, London.

**Knockalower Dispensary District.**—Medical Officer. Salary £130 per annum, with £10 a year as Medical Officer of Health, together with Vaccination and Registration Fees. Applications, accompanied by diplomas and testimonials, to be sent immediately to E. N. Flynn, Clerk of Union. (See advt.)

**Leicester Infirmary.**—Assistant House Surgeon. Salary £80 per annum, with board, apartments, and washing. Applications to the Secretary, 24, Friar Lane, Leicester.

**Lincoln County Hospital.**—Senior House Surgeon. Salary £100 per annum, with board, lodging, and washing. Further information of W. B. Danby, Secretary.

**Margate Royal Sea Bathing Hospital.**—Resident Surgeon to act as Junior for six months and then as Senior for the like period. Salary of the two offices is at the rate of £80 and £120 per annum respectively, with board and residence. Applications to the Secretary, Offices, 30, Charing Cross, London.

**Royal South Hants and Southampton Hospital.** Surgeon and an Assistant Surgeon. Application to T. A. Fisher Hall, Secretary, Salisbury Infirmary.—House Surgeon. Salary £100 per annum, with board, lodging, and washing. Applications to the Secretary, School Board for London.—Medical Officer for the Highbury Grove School. Salary £125 per annum. Further particulars may be obtained on application to C. P. Turner, School Board Offices Victoria Embankment.

## Marriages.

**APPLEYARD—WALTER.**—On Oct. 23rd, at Christ Church, Winstead, Walter E. Appleyard, M.B.C.S., L.S.A., of Ilford, to Zillah Annie, third daughter of Geo. Walter, of Wanstead, Essex.

**COOMBE—JOHNSTONE.**—On Oct. 22nd, at St. Barnabas, Beckenham, Russell Coombe, M.A., M.D. Camb., F.R.C.S. Eng., of Exeter, to Eve Harriet Cartledge, eldest daughter of John Cartledge Hirst Johnstone, J.P., of Beckenham.

**WILSON—HIBBERT.**—On Oct. 24th, at St. Paul's Church, Knightsbridge, London, Walter Frank Wilson, only son of the late Henry Swindon Wilson, of Begent's Park, London, to Ellen Ann (Nellie) Hibbert, second daughter of Chas. H. Hibbert, L.R.C.P., L.R.C.S. Ed., of Marple, Cheshire.

## Deaths.

**APLIN.**—On Oct. 21st, at Hill House, Notts County Asylum, Alfred Aplin, M.D., M.R.C.S., L.R.C.P., aged 47, Resident Medical Superintendent of Notts County Asylum.

**BENNETT.**—On Oct. 18th, at his residence, Sloane Street, London, Francis Graham Bennett, M.R.C.S., L.S.A., aged 59.

**HOLDING.**—On Oct. 17th, at East Hendred Rectory, the residence of his son-in-law, Charles Holding, F.R.C.S., late of Victoria Street, Westminster, aged 93 years and 9 months.

**PEETE.**—On Oct. 20th, at Great College Street, Brighton, Thomas Peete, M.D. St. And., M.R.C.S., L.S.A., aged 76.

# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXIII.

WEDNESDAY, NOVEMBER 6, 1901.

No. 19.

## Clinical Lecture

### LESSONS TO BE LEARNED

FROM

### VEGETABLE PATHOLOGY. (a)

By JONATHAN HUTCHINSON, F.R.C.S., F.R.S.,  
Consulting Surgeon to the London Hospital.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

GENTLEMEN,—It is our intention to-day to endeavour to get some lessons as regards general pathology from the diseases of plants. The first subject to which we will direct attention is the differences between the causes of disease in trees and plants and in animals. Of course I need not say that plants and trees have no heart and no nervous system and no lungs, at least in the sense recognised in animals; and they cannot be killed either by being choked from want of air, or by the strangulation of any trachea. Nor have they any definite oesophagus. Still we find that the general laws of pathology in reference to trees and plants are the same, and I think they are instructively similar to those which we recognise in animals. Of course we have in animals to think of the vital endowments of the solid tissues, and also of the blood which circulates in the tissues. We know that in some cases there is an inherited tendency in the solid tissues to disease, and in some, in the blood and in others, various classes of influence are brought to bear. I would ask you, in looking at a sickly tree or plant, to at once put to yourself the question, Why is it so? and then to investigate the symptoms which the tree displays very carefully, and you will find the same problems suggesting themselves to you as you have in the examination of a patient. Is there anything in the tissues of the tree or its root structure which makes it incapable of prolonging its life beyond a certain duration? Are its organs of assimilation in a certain condition? You will find there is a whole series of facts to be comprehended and investigated in reference to disease affecting the roots. The roots must not be thought of simply as fixation organs, but in their far more important sense as organs for absorption from the ground of the fluids and salts, and other ingredients, by which the plant will be fed and stimulated. If the roots are diseased it is easy to see that the plant or tree will probably be diseased. Next, are the leaves diseased? These stand to the tree as the organs of respiration and the stomach do to the animal. If the leaves are extensively diseased the tree is in the same condition as an animal suffering from disease of the stomach, and unable to thoroughly digest and assimilate his food. It is by the leaves that the fluids are converted into nutriment,

and that the various ingredients are made into xylem or phloem, or other matter as the tree may need. If you should find that the whole tree is sickly—trunk, branch, and leaf—you may take it for granted that either there has been some starvation process at work in the supply of nutriment or some general disease of the roots; and if these be continued the tissues will die. You would not think of referring a disease of the whole tree to that which merely affected its trunk or leaves—at least, not in a general way. To mention an instance in proof of the close connection between the general laws of vegetable and animal pathology, I turn to the subject of competitive nutrition. We have a large cancerous growth in an animal, making great demands upon the nutritive materials supplied by the blood, and, as everybody knows, cancer leads to emaciation and to want of nutrition in various organs. This overgrowth, or inflammation, of one organ is caused by the excess of blood supply to it, and as the result of competitive nutrition the other parts of the body are improperly nourished. We see this general law exemplified sometimes in the case of congenital hypertrophies. One part is endowed in some way with larger vessels than the rest. We have many similar instances in the animal kingdom. I will mention in passing a very interesting example of the suppression of growth under this competitive nutrition which occurs in the case of the walrus and the elephant's tusk. Here is an illustration to show the overgrowth of one tusk and the suppression of the other. In the narwal we also have the most interesting instance of this law in the whole range of zoology. It is a species of whale and has nothing to do with fishes. It has incisor teeth; one tooth has grown to a length of about seven feet, an ivory tusk projecting in front of it; the other incisor is absolutely atrophied. In vegetables we sometimes see this law exemplified in the potato. Many of the plants do not produce flowers. Why is that? Every plant has a destiny to prolong its kind in some way by the production of seeds or tubers. The potato has taken to producing under the ground tubers which have "eyes"—a sort of false stem—from which buds the potato can be propagated, so that the potato no longer needs its seed at all for reproduction; the plant is produced by the tubers or potato root. There is one other curious thing to be noticed about the potato plant. If you take the trouble to gather it you will find the flowers arranged in a bunch, and that the majority of them have dropped off. Take hold of one of the remaining flowers, give it a pull, and you will find it very easily comes off; it is destined to come off, and is loose at a certain place. Thus, the underground tuber takes up the food which would be necessary for the production of seed, and the plant, realising in some obscure way that the production of seed is not necessary, makes no attempt to produce seeds, and the potato bearing a seed is

(a) Abstract of a lecture delivered at the London Hospital on July 3rd, 1901.

now comparatively infrequently found, because the plants have been carefully cultivated with a view of selecting those which produce the tubers. If one part then has a tendency to grow it is at the expense of the growth of some other part, and of the proper nutrition of the whole. Another very interesting instance of the law of competitive nutrition is found in trees, which have a tendency to produce a large number of seeds. The nobilus is one such tree, producing innumerable cones. It flowers when young. The cones are very large. The effect of this great output of cones is that their production absorbs the sap which ought to go to the development of the shoots, and the central shoot, instead of going up six or eight or ten inches, is very much dwarfed by the overgrowth of its seeds.

The diseases of roots are extremely common. Various forms of fungus growth attack the roots of plants just as they may attack the boughs and the leaves; some of the worst diseases of plants occur in cases in which the fungus is growing at the roots.

To go back for a moment to competitive nutrition, I have a most curious poplar tree on my own farm at Haslemere. The roots are divided into two forces, the one going down deep in the earth and branching out, the other going up, not down at all, to the top soil with a view of getting the first supply of rain that there may be and the nutritive fluids, manure, &c., which may exist in the upper layers of the soil. The poplar and some other trees have a tendency to the throwing out of roots from the parent root with the view of fetching for the latter's use various superficial products; sometimes this branching covers an area of thirty to forty square feet. This tree stands near a bank, and therefore its spread is limited on one side. Now, at the end of each of these roots there has grown up a young poplar, which has made its appearance above ground. The result is that the parent tree is killed.

Fungi very often attack the stems of trees where some most interesting lessons may be learned in reference to animal pathology. Sometimes healthy trees will be attacked, sometimes diseased trees, and very often wounded trees. Just the same as you know occurs in connection with diseases in the human subject. We have certain specific animal poisons and fevers which may occur in a perfectly healthy person, and from which good health is no security whatever. Small-pox affords a very good instance of this; it attacks healthy men, in whom there is the best supply of blood; indeed, the latter suffer more severely than others, as if there was more favourable opportunity for the development of the parasitic poison introduced into healthy people. So it is in reference to the attacks of fungi in plants. The fungus exists in immense variety; each species is different and has a different tendency. Some will flourish in perfectly healthy plants, no predisposing influence whatever being necessary to their growth, while others wait till the plant is injured or is sickly, or just dead or nearly dead, before they can attack it. The antiseptic treatment of wounds in plant and vegetable life is of extreme importance as in animals. A wound on the bark of a plant will allow a fungus to settle there and grow into it and the stem, causing disease and gradually converting the woody tissues of the stem into a soft structure, which destroys them. So that fungi act as agents for the absorption of and obstruction of the passage of fluids, which are necessary to the nutrition of the plant. On looking at this piece of wood I have here you will see certain blue lines in the structure of the wood, and a transverse section will show a sort of circle of blue lines. Each blue line is the growth of the fungus. Most frequently they are found along the whole length of the stem, branching but little if at all. In this way the stem

of the tree will be very extensively affected and converted into a structure no longer capable of carrying up the sap. This is not at all uncommon. In that big tree, the Weymouth pine, you will notice—in a great many of them—that a single bough is completely brown. The rest of the tree is quite healthy; some of the boughs stand at a considerable height. Examine this brown bough, and you will likely find on it a scar where some little injury has occurred. It may have been caused by a bird, or a hailstone, or a blow. Anything breaking off the bark will permit the entrance of the fungus, which once implanted in the injured spot, will pass into the stem. These fungi differ in their growing tendencies; they will grow far into the bough, and sometimes not. In the instance I am now mentioning there is a local death from local implantation of the fungus.

A very curious fact was observed at Haslemere, which is of interest to those who are engaged in the life-history of the fungi. We found on a Weymouth pine a very common fungus called the peridermia stromi. This fungus has been known on the Continent for a long time to be liable itself to be attacked by fungus. We found, for the first time I believe in England, this second fungus. It is very difficult to account for its origin. The authorities at Kew Gardens told us that it had not to their knowledge been previously observed in England. There is evidently some law of association between these two fungi.

I have previously hinted that the protection of a wound from infection is just as necessary in the case of a plant as in an animal, but, of course, in the great majority of instances it is not a practicable measure in the plant. If the tree is a valuable one, sometimes the bough is cut off if it is not possible to protect the wound from infection. Or the wound may be smeared with some antiseptic tar to prevent the entrance of fungus. Fungus is apt to destroy fir trees on a large scale by inducing decay of all the middle wood, and it creeps up the whole of the stem of the tree. All rot is the fungus growth; all decomposition is due to fungus. The source of infection in these firs is believed to be by the roots and through the agency of rabbits and rats. The rabbit burrows under the fir tree and eats the bark-root, thus causing injury. The rabbits then run about under other trees and gather the spores of the fungus, and in running again under its burrow where it has already broken the bark-root, the spore is deposited. In this way the fungus gains access to the tree.

Another point of great interest in fungus life in trees and plants is the fact that the fungus in some of its varieties would appear to be capable of prolonged periods of latency, ceasing growth and remaining inactive. Here we have another important lesson corroborating what I said the other day in regard to tubercle bacillus, *i.e.*, that it could remain a long time in the tissues of the human body without producing any morbid influence whatever. There are hundreds of instances in vegetable pathology in illustration of this fact. The fungus is present in one case, and yet there is no active disease; in another case there is no fungus visible, and yet a good deal of disease.

As regards idiosyncrasy in trees. In animals we make great allowance, but not too much, for original differences, of which we can detect no evidence until disease attacks the individual, and then we find that no two individuals are affected in the same way by the same disease. To this great fact we give the name idiosyncrasy, and by this word we recognise that each individual is differently endowed, and reacts in a peculiar way to the influence of a poison. It is frequently coincident with a condition which does not reveal itself. Idiosyncrasy is a personal

peculiarity which is just as real in the vegetable world as in the animal. I have another idiosyncrasy to give you. In the illustrations I have passed round there is one of two oaks standing near together in the same field. They are of the same age and in equal good health; as far as I can tell they have been reared under exactly the same influence; they are of the same species of oak. Now, you will see one tree has kept its leaves on throughout the winter though they are brown and dead; it ought to have shed its leaves last autumn. The photograph was taken in April this spring. The other tree has, in the usual way, no leaves of last year on it. The former oak is endowed, in other words, with a personal property by which it keeps on its autumn leaves. The retention of summer foliage in the winter, especially in small beech trees which grow in hedges, is often seen. Yet by their side stand other beeches in the hedge exactly similar, but they shed their leaves. We can give no explanation of this, but I would suggest, in the case of the oak tree, that the retention of the foliage is an attempt on its part to become an evergreen. This is in accordance with the laws of variation. These laws, as explained by Darwin, lead to the development of species. So our oak may be in a transition stage, for it does not keep its leaves green, but keeps them on.

Another lesson which we may get from the presence of fungi relates to the laws of diffusion. I quite expect that you are taught in the medical and surgical theatres that the disease known as tetanus is due to a specific form of microbe, and is due to inoculation. I am not going to dispute that statement, but there are certain facts which render it difficult of explanation. Enlightenment may be thrown on the subject by the examination of what occurs in vegetable life. Is it not very curious indeed that the germ which produces tetanus should be so widely diffused and yet so seldom produces itself? If it is a specific germ one would expect to get a whole lot of tetanus cases, but as it is we get a case here and there, and there is never an epidemic. I am referring to England only, for we know tetanus is much commoner in tropical climates. We have some similar facts in reference to vegetable disease. In the Weymouth pine the fungus is extremely common, and exists almost solely on that tree. There are many questions in reference to the laws of diffusion of these germs of fungi which form interesting food for study. To a certain extent—to a very great extent—science has enlightened us as to how these germs are to be sought, and has enabled us to destroy them. Here I would allude to another branch of the subject which is of great interest, and extends a little caution to us in being too quick to draw inference from rather incomplete examination of the facts in reference to the different species of fungi. I would suggest that we be a little cautious in inferring that, because the external appearance produced by the disease which we know as *tinea versicolor* and that which we know as ringworm are very different; therefore it is certain they are not transmutable. I believe one cause produces pityriasis, *tinea versicolor*, *tinea favus*, ringworm. My belief is that you can from the fungus of the common ringworm found on a collection of children produce any one of these or spots on the skin of the chest of an adult. I have seen many instances in which young nurses carrying children with ringworm have not developed ringworm, with the appearance of which everyone is familiar, but *tinea versicolor*, with the appearance of which one is equally familiar. The fungus may modify its form of growth, or the same fungus may produce the two diseases. I believe that the same fungus produces the two diseases. A great lesson has

been given to us with regard to the disease which produced rust in the wheat—that disease in which the leaf of the wheat becomes brown all over and dies prematurely. The crop is injured by the destruction of the leafage. This “rust” also occurs in some grasses. On account of the importance and value of the wheat, the word “rust” is more particularly associated with that cereal. The prevention of the disease was an urgent question to the farmers and botanists. The former observed that where a common barberry grew in the hedges of a wheat field there was likely to be rust in the wheat. The botanists said there could be no connection between the two plants, as there was one fungus which grew on the barberry, and the fungus producing the rust was quite different. The species were different. The farmers held to their original belief and acted on it, in spite of scientific teaching. They got rid of the barberry trees, and in so doing got rid of the rust. A law was passed in Massachusetts that all barberry trees should be exterminated to prevent wheat rust. Strict measures were taken to put this law into effect. The great discovery was then made that the barberry tree was one whose leaves had two hosts, and it was actually the same fungus which produced wheat rust as was found on the barberry. It was a case of transmutation due to two different stages of development of the fungus. The wind scattered the fungus seeds over the fields of wheat. Here was an instance where science lagged behind the observations of practical men. We must not urge a statement too strongly until we are quite sure of its truth, as approved by the general verdict of experience. Learn when and where you can; listen to everybody; but do not forget to take into account errors to which all are liable, and listen to those who have had opportunities of making practical observations, even though their remarks may not appear to conform to the scientific truth. Even so with regard to the study of forms of disease. We shall very probably with further study simplify remarkably our opinion regarding variety of form of diseases. Many of the present distinctions are not really true.

I turn now to quite a different subject, and that is the effect of introducing disease and living parasites upon plants. One is the formation of galls, of which you see a specimen before you. It is developed at the root of certain stems and looks like a cone; it is sometimes called a pineapple cone. But it is not a seed cone though it looks exceedingly like it. This specimen is from a Norwegian spruce. It is caused by the presence of an insect, but not made by the insect, which is a member of the ubiquitous aphides. The mother aphid deposits her eggs at some point of the tree where a stem is about to bud. The plant mistakes the irritation produced by the eggs for the irritation produced by its own living seeds. It is obvious that the local irritation cannot be exactly appreciated by the tree. The result is the production by the plant of something very like a cone. Remember the insect takes no share in building up the gall, which serves as a nest for its larvæ. In some firs the gall is produced at the very top of the boughs. Of course, the kind of gall depends upon the tree and its tendencies. It is interesting to know that some trees of the same family are so much alike that the easiest means of distinguishing them is by the diseases of the cones. The character of the gall also depends a great deal on the precise part of the tree which is attacked. There are an immense variety of galls. In the oak you may have several kinds of gall on the same tree. The time of the year and the condition of the circulating sap are important factors in their formation. Such are the general laws.

## CÆSAREAN SECTION : WITH NOTES OF THREE SUCCESSFUL CASES. (a)

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AMONG the cases of extreme pelvic deformity which have been under my care in the Glasgow Maternity Hospital during the present year, and since my appointment as obstetric physician to that institution, there have been three in which I deemed it advisable to perform Cæsarean section. These cases I venture to bring under your notice to-day.

Before giving a brief summary of the individual cases, let me shortly refer to a few details connected with the operation as it was performed.

In the Glasgow Maternity Hospital, since April, 1888, when Professor Murdoch Cameron performed the first successful Cæsarean section, the operation has been performed somewhere between sixty and seventy times. Of the cases that have proved fatal, with only two or three exceptions, the cause of death has been septicaemia, and, further, the infection in the majority of cases, as far as could be judged, has been from the vagina and cervix, and not through the abdominal opening. This, I think, is a most important point, and one that has not been sufficiently emphasised. The reason for it is evident. On the one hand, the skin is sufficiently cleansed with comparative ease, and that as a matter of routine nowadays; while, on the other hand, the vagina and cervix, if septic, are difficult to disinfect, especially the latter, and attempts at doing it are, as a rule, carried out in a more perfunctory manner.

To get the best results I am quite convinced we must suspect the vagina in all cases of containing pyogenic organisms, and adopt means to remove them. This is especially true of cases that have been handled before admission to hospital, but is also true of some few cases which have never been examined. The investigations by Döderlein, Menge, and others have demonstrated the occasional presence of pyogenic organisms in the healthy vagina and cervix, and all of us have had experience of cases of septic infection in the puerperium where there has never been any examination made either before or during labour. Now, simple douching, the usual routine, I do not believe is sufficient; the vagina, especially the vault and the cervix, must be carefully swabbed with some antiseptic solution. In the cases to be related, 15 to 20 oz. of a 1 per cent. solution of lysol was used. I would have preferred to use perchloride of mercury, but it constricts the canal to such an extent that it is extremely difficult to swab it out. The skin was cleansed by scrubbing with soap and water, turpentine, alcohol, and carbolic solution, as is so generally done.

No sponges were used—only sterilised absorbent swabs. About thirty are required for each operation, as no one is used twice. One nurse wrings them out of hot sterilised water, another collects and counts those that are soiled.

After opening the abdomen, swabs were placed round the uterus, but the latter was not pulled out through the abdominal opening until after it had been emptied of its contents. The opening into the uterus was always longitudinal and in the middle line, the bleeding in cutting through the wall being controlled by the vulcanite ring recommended by Cameron. It always acted very satisfactorily, and allowed me to cut down on to the membranes with-

out having the wound flooded with blood. After the child was extracted, my assistant grasped the uterus firmly with fresh swabs, and controlled the bleeding. I never used elastic tubing to control the bleeding. In each case the placenta separated immediately after the child was extracted, and it and the membranes were readily removed.

In two cases the uterus was sutured with Hartmann's catgut boiled for half an hour in a Jellott's steriliser. In the other case sterilised silk was used.

Each of the patients was sterilised by tying the Fallopian tubes in two places, and dividing them between the ligatures.

In each of the cases labour was in progress, and in two had advanced considerably, before the operation was commenced.

CASE I.—Mrs. L., 33, iii-para, was admitted to the Maternity Hospital under my care on March 15th, 1901. In each of her two previous labours craniotomy had to be performed before the child could be extracted.

On examination, the os was fully dilated, and the membranes were ruptured. The oblique conjugate was found to be  $3\frac{1}{2}$  inches, and the transverse diameters were slightly under the normal. The presenting head was freely movable above the brim, although labour had been in progress for twenty-four hours. The fetal heart-sounds were strong, regular, and numbered 140 per minute.

The operation was carried out by making the usual longitudinal incision through the abdominal wall and anterior uterine wall. The child was easily extracted by the head, but in doing this the lower end of the wound was increased by slight tearing of the lower uterine segment. The child, a female, cried lustily soon after its birth. It weighed 7 lb., and measured 19 inches. The placenta, which was situated on the posterior wall of the uterus, became immediately separated, and was easily removed along with the membranes. The woman was sterilised by tying and cutting the tubes as described.

The uterine wound was closed with silk. The abdominal wound was closed in one layer with silk-worm-gut.

The puerperium was very satisfactory, and the woman's progress to recovery rapid after the first few days. The temperature never rose above the normal, except the morning after the operation, when it registered  $100^{\circ}$ . The pulse, however, for the first few days was very rapid, and gave cause for considerable anxiety. On the evening of the second day it registered as much as 160, but fell on the third day to 108. This rapid rate was attributed to a very bad bronchitis which developed immediately after the operation, and was caused, I feel sure, by the irritating fumes of chloroform and gas. The stitches were removed on the fourteenth day, at the first dressing, when the wound was found quite dry and healed.

The woman was dismissed on the thirty-fourth day, both she and the child being perfectly well. She began to nurse the child on the tenth day after she had recovered from the bronchitis, and continued doing so until she left the hospital.

Note to Case I.—The most striking feature in this case was the alarming bronchitis which developed after the operation, and which, I think was correctly attributed to the irritating fumes of the chlorine set free by the coal gas, the only illuminant we have in the hospital. I have seen the same complication occur once or twice before in cases operated on during the night, but never in such a severe form. The woman was really extremely ill.

CASE II.—S. O., primipara, 23 (?), was admitted to the Maternity Hospital under my care on April 19th. On examination, the os was found fairly well

(a) Read at the Annual Meeting of the British Medical Association held at Cheltenham, 1901.

dilated, and the membranes unruptured. The C.D. measured  $3\frac{1}{2}$  inches, and the C.V. I estimated at  $2\frac{1}{2}$  inches. As the fetal heart-sounds were strong and regular, it was decided to do Cæsarean section. There was, unfortunately, some delay in getting the patient ready, so that the operation was not commenced until three hours after the patient's admission. The operation was performed in the usual way, and the child extracted without the least difficulty. The placenta, which was situated on the postero-lateral wall, immediately separated, and was removed along with the membranes. Unfortunately, the child, a female, was dead, no trace of a heart beat being appreciable. It weighed  $7\frac{1}{2}$  lbs., and measured 22 inches. The uterine wound was closed with catgut, and the abdominal in one layer with silkworm-gut. The woman was sterilized by tying and cutting the tubes as described.

The recovery of the patient was most satisfactory. The only feature of special interest about the puerperium was the scantiness of the lochial discharge. At first this rather alarmed me, especially as during the first four days the temperature was never much below the  $100^{\circ}$ , and on the evening of the fifth day registered  $101^{\circ}$ , and the pulse was often running as high as 120. However, these slight disturbances in pulse and temperature disappeared by the sixth day. The lochia all through was very scanty.

The stitches were removed on the fourteenth day, at the time of the first dressing. The wound was quite dry and healed. The patient was dismissed from hospital on the thirty-second day, quite recovered.

*Note to Case II.*—It is extremely unfortunate that the child was dead in this case, as it was chiefly on its account that Cæsarean section was performed. My colleague, Dr. Jardine, very kindly saw the case along with me, and we both considered it one of those cases where, as regards the mother, the risks from craniotomy and Cæsarean section were about equal—if anything, a little in favour of the latter. The child being alive, however, we decided on Cæsarean section. Unfortunately, I did not listen for the fetal heart immediately before commencing the operation, as three hours before, at the time of the patient's admission, I heard it quite strong and regular. The child must have died in the interval, and not, I think, during the early stages of the operation.

**CASE III.**—Mrs. B., æt. 26, ii-para, was admitted to the Maternity Hospital under my care on April 15th, 1901, for the purpose of being delivered by Cæsarean section. Her pelvis was very markedly deformed in the conjugate diameter, but little affected in the transverse. The C.D. was  $2\frac{3}{4}$  inches, and the C.V. was estimated to be 2 inches. Her previous pregnancy terminated at full time, the child being delivered with difficulty after craniotomy had been performed.

Labour in this second pregnancy began on the 25th. Dilatation of cervix was rapid, so that before the patient was ready for operation the os was fully dilated and the membranes had ruptured. The fetal heart was heard beating strongly immediately before operation.

The operation was performed in the usual way. There was great difficulty, however, in extracting the child as the uterus grasped it so firmly. It was delivered alive, but in doing this the uterine wound was enlarged by slight tearing of the lower segment.

The child, a female, cried immediately after it was born. It weighed  $6\frac{1}{2}$  lbs., and measured 21 inches. The placenta was situated on the posterior wall, and separated immediately after extraction of the child. The uterus was closed with catgut sutures, and the tubes were tied and divided as

described. The abdominal wound was closed in two layers with catgut and silkworm gut.

The patient's convalescence was very satisfactory until the fourth day, when in the morning the temperature rose to  $103.2^{\circ}$  and the pulse to 162, the lochia became fetid, and there was diarrhoea. I at once douched out the vagina and then the uterus with a solution of 1 in 2,000 perchloride of mercury. This had the desired effect, for the same evening the temperature was  $100.6^{\circ}$ . On the eighteenth day there was again a slight rise of temperature. The stitches were removed on the seventeenth day, when the wound was found quite healed and dry. She was dismissed from hospital on the twenty-eighth day. The only thing that was not just satisfactory was that she seemed unable to completely empty her bladder, as each time it was catheterised, and this was done several times after she had micturated, there were several ounces withdrawn.

*Note to Case III.*—The difficulties in extracting the child were very considerable. This was not due to the small size of the wound, but to the strong uterine contractions. Considerable advance had been made before it was discovered that the patient was in labour. As has been stated, the os was fully dilated, and the membranes were ruptured before the operation was commenced.

In this case a slight septic infection occurred, and it was from the vagina or cervix almost certainly.

The cases just described, along with those published this year by Cameron (a) and Sinclair (b), indicate the comparative safety of the operation of Cæsarean section performed under favourable conditions. Such a state of matters is cause for great satisfaction; it permits obstetricians to recommend the operation with great confidence, and under less restricted conditions than formerly prevailed. In cases of pelvic deformity we are now hardly ever justified in destroying a living child by craniotomy or any other destructive operation. The only circumstances, indeed, under which such operative measures are permissible, are where fruitless attempts have been made to extract the child with forceps or version from ignorance of or miscalculation of the extent of the pelvic deformity, where the mother's condition is such as to preclude abdominal section, and where the child is the subject of hydrocephalus or some other extreme malformation, or is on the point of dying.

As far as I can see there is no other position tenable now by those who practise obstetrics as a specialty. That the pregnancy is illegitimate cannot be considered as some would have us do. With such a circumstance we dare not concern ourselves. Nor is the fact that a pregnancy is a first any argument against Cæsarean section if the conditions clearly indicate the impossibility of delivering the child alive *per vias naturales*. The line of practice indicated is very clear and distinct, and by following it we are faced by no subtle ethical problems. The following of it is occasionally prevented, however, by one circumstance—the refusal of the patient to consent to the operation. It rarely happens. If it does, and the woman is in labour, there is no alternative but to do craniotomy, unless that is impossible owing to the extreme degree of pelvic deformity. If the woman is not in labour one can only refuse to do anything to do with the case. Some little time ago a woman came to me far advanced in her fourth pregnancy. In all her three previous labours the child had to be destroyed by craniotomy, and she wished to arrange for the same operation being done for a fourth time. As she refused to submit to Cæsarean section, there was nothing for it but to

(a) "Glasgow Hospital Reports," vol. iii., 1901.

(b) *Lancet*, January 19th, 1901.

decline to treat her, which I did. No self-respecting man can go on destroying children indefinitely.

But the good results now following the Cæsarean section cause another and very important question to be asked, viz., should we sterilise the woman after performing the operation? Cameron, in his most recent paper on Cæsarean section, says—"A very important point in favour of Cæsarean section is that the Fallopian tubes can be tied and divided so as to prevent subsequent conception." It has been the custom in Glasgow, following Cameron's teaching, to do this, and in the cases related I have done so also. Such a position now is hardly tenable, however, for the two great arguments in favour of sterilising do not hold good any longer. They are—(1) That the operation of Cæsarean section being so dangerous, and so frequently fatal, it is not desirable to submit a woman to the risks of it a second time; (2) that there is great danger of the sutured uterus rupturing should the woman again become pregnant. I say, with our present-day experience, neither of these arguments hold, and sterilisation should not be the routine practice.

In all these cases the operation was performed after labour was in progress for some time. In the first two that was unavoidable, for the women were in labour when admitted, but in the third case it was done intentionally because it has been the custom in the hospital. To judge by reported cases, however, it is not necessary, and it is undoubtedly much more convenient to fix beforehand the time of operation. One can choose the day time when there is good light, and one can have all preparations for the operation more leisurely and thoroughly carried out. But, to my mind, much more important than either of these advantages is that the lower uterine segment has not developed, and the actively contractile portion of the uterus has not retracted, consequently one can open into the uterus through the latter part more easily and with a lower incision. In two of the cases just detailed there was some tearing of the lower uterine segment. It is most desirable not to wound that part, and it is not easy to prevent it with the ordinary incision and if the segment is well developed, because the tear is difficult to control, and because the wound is brought down near the cervix and vagina, where any pyogenic organisms, if present, are most likely to be found.

In all the three cases the incision was longitudinal, and only in Case III. was there the least difficulty in extracting the child. The only advantage of the fundal incision, "nach Fritsch," as far as I can see, is that the wound is removed away from the most probable source of infection. There are weightier objections to it, I fear, on which, however, as I have no experience of the incision, I will not speculate.

In all three cases the placenta was situated on the posterior wall of the uterus. A very striking feature was that the placenta became separated immediately after the birth of the child. Might not the much-discussed cause of the separation of the placenta be answered by observing the separation after Cæsarean section?

I also observed that in all three cases there was only about a third of the circumference of the uterus between the tubes in front, and so confirmed Leopold's statement that, with the placenta on the posterior wall, the tubes are closely approximated in front. That the contrary is also true I have not been able to confirm.

In two cases I confirmed Cameron's contention that the back of the child is always towards the opposite wall to which the placenta is attached.

In a small portion of the Fallopian tube excised in one case, I did not find decidual changes in the cells of the mucous membrane.

## AVENUES FOR MEDICAL PRACTICE : THE ARMY MEDICAL SERVICE.(a)

By THOMAS MYLES, M.D., B.Ch., F.R.C.S.,  
President of the Royal College of Surgeons, Ireland; Surgeon to the Richmond Hospital.

AFTER some introductory remarks, Mr. Myles referred to the openings which the medical profession presented to the newly-qualified medical man. He said:—Now, speaking broadly, the average young qualified medical man has three courses open to him. First, he may elect to settle in private practice at home. Secondly, he may elect to seek an appointment under the Crown as Colonial surgeon. Thirdly, he may elect to enter the Medical Service of the Navy or Army. At the present moment, as most of you are aware, our professional world is agitated by the report of the Commission appointed by Mr. Brodrick, Secretary of State for War, to draw up a scheme of Army medical reform. Now, before I proceed to discuss this scheme in any detail I want not only to make my own position as official head of this College, but that of others who may be similarly situated to myself, perfectly clear. It has been alleged that the Medical Schools have boycotted the Army Medical Service, and in consequence of this boycotting there has been a dearth of suitable candidates for the vacancies occurring in recent years. My answer to that statement is a very simple one, and I think you will agree with me in saying that it is strictly in accordance with the truth and the facts of the case. It simply is that if the Army Medical Service is really made attractive, not all the blandishments or persuasive eloquence of presidents or professors can keep men from offering themselves for vacancies therein. The stress and struggle of competition in our profession is so great that I am convinced that a large proportion of highly qualified young men would embrace, even at a considerable pecuniary sacrifice, the assurance of a certain income under the Crown, if such assurance were not accompanied by very grave disadvantages. Again, let me add to this preamble by stating that in my opinion the profession as a whole owes a debt of gratitude to Mr. Brodrick for the work he has done in this connection. Now, what are the improvements in the proposed scheme as compared with the terms at present in force? First and foremost is the improvement in the examination for admission to the service. The diminished importance that will in future be attached to the elementary scientific portion of the examination, and the increased importance that will be attached to the vitally important subjects of medicine, surgery, &c., is undoubtedly a step in the right direction. Another point which undoubtedly will conduce to the well-being of the service is the establishment of an Advisory Board. On this Advisory Board will be four civil medical men, two surgeons, and two physicians. The presence of the civil element on the Board should be of great benefit to the entire service. As the civil representatives will be changed at frequent intervals, there is little likelihood of the Royal Army Medical Department lagging behind the times, and it will be at the same time a guarantee to the officers serving that efficient work in any department will not fail to have due recognition. Again, the scheme provides for the formation of a sub-committee, on which the civil element will be represented for the inspection of the military hospitals at intervals, and for reporting as to their relative efficiency, &c. Moreover, in the all-

(a) Abstract of the Inaugural Address delivered at the Opening of the Winter Session, Royal College of Surgeons of Ireland, 1901-1902.



important matter of pay, the proposed scheme in many points compares favourably with that now in force. Beyond question, when one considers the certainty of the income and the comparatively easy life of the Army surgeon, the terms I have detailed to you compare favourably indeed with that of the average civil practitioner. The blemishes on the scheme so far as you are concerned, to my mind, are three. The first of these is the uncertainty which exists at present as to the terms under which an officer may retire, who, having served six years in the rank of captain, has failed to pass the subsequent examination. Doubtless through an oversight, it appears from the scheme that, while an officer before the examination may retire with a gratuity of £1,000, yet, should he elect to present himself at the examination and fail, he is compulsorily retired without any compensation. In other words, he apparently must risk £1,000 on the chance of passing an examination. I cannot bring myself to believe that this was the intention of the Committee, it is so manifestly unjust and unfair, and I have every hope that on revision uncertainty on this point will disappear. The second blemish in the terms appears under the head of paragraph 43 and those following. These paragraphs state that an officer after serving eighteen years is liable to be compulsorily retired with a gratuity of £2,500 in the event of his failing to pass a certain examination. This seems hardly fair. Under the proposed scheme a man is liable after eighteen years' service to be compulsorily retired on a pension which cannot be more than £150 a year, and may be very much less. Doubtless the object of this proposal is to weed out from the service incompetent men, and equally, without doubt, to do so is not only right, but absolutely necessary. Surely some method other than that of examination could be adopted for determining the efficiency or inefficiency of officers of mature age. Now let me say a word about the Advisory Board. Sir William Thomson, who had a place on the Consultative Committee, has very rightly drawn attention to the composition of this Board. This little country of ours supplies a very large number, I might almost say a disproportionate number, of the officers serving in all branches of his Majesty's army, and I think, therefore, we are fairly entitled to some representation on that Board. Under the terms of the present scheme such representation is absolutely impossible. The honorarium assigned to each member of the Board is £200 per annum, and as the Board meets fortnightly, or twenty-six times a year, it would mean that any Irishman appointed would have to be at least three days in every fortnight away from his home and business. This, of course, practically excludes this country from representation on the Board. There can be no doubt that young Irishmen would be more attracted to the service if they felt that in the event of any unjust treatment being meted out to them they had a fellow-countryman at headquarters, to whom they might confidently apply for redress. The leading daily papers and distinguished military officers speak of the details of the scheme as "concessions" to the medical officers, who ought now to be thoroughly satisfied at last. There can be no "concession" to you who are not yet in the service; improvement in the conditions of service may be perhaps regarded as concessions to the men already in it, but to you who are not in it the term "concessions" is utterly inapplicable. The Secretary of State for War is not making any concessions to anyone. He is coming into the open market, which is regulated by the laws of supply and demand, and he has simply offered better terms in the hope of getting more men of a better class than hitherto. If the terms are good enough he will get plenty of good men; if they are not the service will remain undermanned as at present.

## NOTES ON THE LATEST RESEARCHES IN THE ORIGIN AND PROPAGATION OF MALARIA.

[FROM A CORRESPONDENT.]

THE October number of the *Indian Medical Gazette* contains several items of interest illustrative of the very important—and, just now, very prominent—subject of malaria. The first of these is a note on "The Occurrence of *Anopheles Funestus* and *Anopheles Costalis* in India." This appears under the triple responsibility of J. W. W. Stephens, M.D. (Cantab.); S. R. Christophers, M.B. (Vict.); and S. P. James, M.B. (Lond.), Captain, I.M.S. The communication reveals the very significant fact that the two species of *Anopheles* named in the title, although not previously described as occurring in India, have been found by the authors to be prevalent in the planting district of the Duars. As they truly observe, "the interest of the discovery lies in the fact that they are the two species of *Anopheles* which carry malarial infection in tropical Africa. It is worthy of note that *A. Funestus* and *A. Costalis* should occur commonly in the district of India where blackwater fever is most frequent.

At the present period, when so many keen observers and accomplished naturalists are engaged in concentrating all their rays into a single focus for the illumination of the dark places of malaria, let us venture to express the hope that this significant discovery will soon prove pregnant with means for the future diminution of the baneful effects of that terrible scourge of the human race.

Encouraging it is in this direction to find in the same issue of our contemporary a first instalment of a very carefully prepared communication by Wm Glen Liston, M.B., Captain I.M.S., from the Research Laboratory, Bombay. The title is "A Year's Experience of the Habits of *Anopheles* in Ellichpur." This very able article has reference only to the northern part of the Deccan; in particular the Ellichpur District, which is situated about the 21st parallel of northern latitude and 77th meridian of eastern longitude. It is necessary to bear this geographical fact in mind, seeing that, as the writer himself points out, the habits of *anopheles* differ in different countries and in different parts of the same country where that country is a large one such as India. The region regarding which the investigations of the writer have been carried out extends southward from the Satpura range of Central India hills with lateral expansions to east and west as a vast black cotton plain. The annual rainfall is about thirty-five inches, and the year may conveniently be divided into two seasons or periods: (1) June to October, "the rains"; at this time all rivers and streamlets are full, and many ditches and drains contain water; (2) the rest of the year "the dry season," when the rivers are small, a mere trickle, with here and there a pool of water in their beds; even these in the latter part of the season dry up, and it is then difficult to find any piece of open water. The soil of this district is that known in India as "black cotton soil"; it lies on the surface of decaying rocks, having at a depth of about ten feet the stratum of hard "murrham," which develops from the weathering of rocks, especially those which contain lime. At the commencement of the rain the breeding places of the *anopheles* larvæ are few; they increase during the rainy period, and are most numerous at the beginning of the dry season. The collections of water in which *anopheles* are found at this time are generally shallow collections of water, seldom more than two feet deep; they are of small size, not more than ten yards, and more frequently only a few feet in longest diameter. In this important district malarial fever "has a very definite seasonal variation. The number of cases reaches its maximum just at the close of the rains, and it falls to a minimum at the commencement of the hot weather." Most careful observations of the habits, life-history, and reproduction of the *anopheles* have been collected by this observer.

The result will undoubtedly be an important additional light on the connection between it and the regional plague of malaria. We shall withhold further observations till this further communication has been completed.

Then Dr. Leonard Rogers, Officiating Professor of Pathology, Medical College, Calcutta, furnishes his contribution to the malarial discussion under the title of "The Effect of the Silting up of a Lower Bengal River on the Prevalence of Malaria; with Some Remarks on the Spleen Test, and the Reduction of Malaria by Filtered Water." The author's investigations were made in connection with an inquiry into the effect of the silting-up of the Karatoya River on the health of the Bopa district. The inquiry arose from a petition which the native inhabitants of the district had submitted, stating that ever since the diversion of the main current from the Karatoya River into the Bergali about half a century ago the former had gradually silted up "and has already become a source of great unhealthiness to extensive tracts on either side." The author's inquiries have shown that "the most silted-up part of the river is the most healthy one, and *vice versa*." But he admits that this observation applies to the present period only; it may not have been so in the earlier years of the physical change. He attaches great importance to the value of the "spleen test"—which some recent authorities have treated with diminishing respect—as a test of the regional infectiveness of a district. His examination of children's blood for the malaria parasite was found to be very tedious, and, in the end, entirely unconvincing. He admits, however, that if such investigation could be carried out in the fever season, which his was not, the results might have been more definite. The writer also dwells on the curious points of striking contrast presented by the features of malarial fever in India and in West Africa. The less common infection of young children in India is very striking, and the difference of frequency of enlargement of the spleen in the malarial fever of the Dark Continent is certainly a very striking phenomenon. Total absence of splenic enlargement in the malarial fever of Central Africa is noted, while 70 per cent. of cases in the neighbourhood of Calcutta were found by the writer last year to present the well-known ague-cake.

The number of skilled and enthusiastic investigators who are at present simultaneously engaged in endeavouring to unravel the phenomena of malaria cannot fail to give confidence to the scientific world that the heart of its mystery must soon be plucked out.

## Clinical Records.

### ADELAIDE HOSPITAL, DUBLIN.

*A Case of Otitis Media Acuta, with Implication of the Lateral Sinus Operation—Ligature of the Internal Jugular Vein—Recovery.*

Under the Care of S. HORACE LAW, M.D., F.R.C.S.I.,  
Throat Surgeon to the Adelaide Hospital, and Surgeon to  
the Dublin Throat and Ear Hospital.

THE interest of this case centres mainly round the short history and rapid onset of dangerous symptoms, with the complete relief afforded by the operation and the subsequent uninterrupted recovery.

R. T., male, *æt.* 19, was admitted to Adelaide Hospital, Dublin, on February 25th, under the care of Dr. Beatty, complaining of having felt unwell and having had some slight pain but no discharge from his right ear for some days previously. His symptoms before admission consisted principally of headache, vomiting after food, constipation, and pain in front of left shoulder, as well as the pain in his right ear mentioned above. On admission, temperature was 102.6°, pulse 136; there was also some cough with slight expectoration and some albumen in the urine. The temperature rapidly fell and remained normal till March 7th, when it again rose, and he complained of soreness in his neck and some headache. I first saw him on March 11th, and diagnosed acute otitis media, and saw some granulations in the external auditory meatus of the right side; there were

no mastoid symptoms, but there was swelling and tenderness in the course of the internal jugular vein, and patient seemed very ill indeed. Up to this time he had not complained of much pain, and had had no rigors, except for one said to have occurred before admission.

March 13th.—A little cough and some frothy sputum, his condition otherwise remaining much the same.

14th.—Condition more serious, some cough with a little rusty sputum; a whitlow was noticed on index finger; and at 10 a.m. he had a severe rigor, temperature 105.8°, all pointing to a spreading septic infection. As he was getting rapidly worse and becoming comatose, a consultation was held and operation decided upon, the diagnosis being acute otitis media with partial or complete thrombosis of the lateral sinus.

Operation performed on March 14th.—Patient having been anaesthetised and the side of head and neck cleansed as far as possible, I made the first incision opposite the cricoid cartilage and tied the internal jugular vein with two ligatures one inch apart. I then proceeded to the operation behind the ear, and made the usual incision, from which there was free hæmorrhage (probably due to the ligature of the vein), and opened the mastoid antrum in the ordinary way after the method of Schwartz. A small amount of pus was found in the cells and antrum, and the bone in the antral region felt soft. I next proceeded to work down on the lateral sinus, using a full-sized gouge to enlarge backwards my opening for the antral operation. The moment the bony wall of the sinus groove was opened pus flowed out, in quantity about half a drachm. I then laid bare the wall of the sinus for about an inch of its length, and found it covered with granulations and a dark slough on the upper part of the exposed portion. The sinus pulsed freely, and did not seem to be completely thrombosed, so I omitted to open it, and decided to do nothing more. The ends of the upper incision were brought together with a few stitches, and the cavity in the bone plugged, the jugular vein was cut across between the ligatures and the lower wound sewn up. The condition of the patient under the anaesthetic was not all that could be desired as he required oxygen nearly the whole time. After the operation, the temperature varied up and down for ten days and then finally came down, his condition improving meanwhile. He was allowed up one month after the operation, the upper wound having nearly granulated up, and the lower one having long since completely closed.

Bacteriological examination of the pus gave diplococci as its principal contents.

As will be seen by the above, the diagnosis was substantially correct, the sinus was inflamed and covered with granulations, so that one may safely say that the internal coat could not have remained normal, and therefore a partial septic thrombosis was certain, which is entirely borne out by the presence of the rusty sputum and cough, and by the occurrence of an abscess which afterwards formed on one of his toes.

The path of infection seems to have extended backwards through the antrum, though there were no antral symptoms at all to help the diagnosis.

April 26th.—There is now no discharge from the ear, and the drum has nearly regained its normal appearance. He hears whispering voice at about two yards on the side affected.

### CYSTIC SARCOMA OF BREAST.

Under the care of Dr. HERBERT SNOW.

A LARGE breast, which had been removed owing to the presence of an intra-cystic sarcoma. The specimen (·) weighed, even after the escape of a considerable amount of fluid, 6 lbs. 12 ozs., being heavier than any the author had ever had occasion to excise. For comparison he showed the photograph of another such growth *in situ*, which had been subsequently removed and found to weigh 4 lbs. 4 ozs. The patient was an eccentric maiden lady, *æt.* 52, whose breast had been the site of a tumour for at least twenty years, the late Sir James Paget

(·) Shown before the British Gynaecological Society, October 10th, 1901.

having then advised its removal. The mass was mobile. Large vessels covered the surface of the skin, which, however, was not ulcerated. There were no enlarged glands. Operation was resorted to only when the pain from distension became agonising. The growth, a congeries of cysts filled with pulpy tissue, on microscopical examination, showed the usual characters of a rapidly growing spindle-celled sarcoma. The patient made a favourable recovery. It was remarkable that no rise of temperature had taken place during convalescence; the chart, which was also before the Society, showed that it had been subnormal throughout.

## Transactions of Societies.

### SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

MEETING HELD AT THE CHILDREN'S HOSPITAL, GREAT OSMOND STREET, LONDON, OCTOBER 18TH, 1901.

Dr. D. B. LEES in the Chair.

*Cerebral Diplegia.*—Dr. FENNELLS showed for Dr. Garrad a case of cerebral diplegia in a child, *æt.* 5½, which presented some points of interest. Ataxy was associated with spasticity and retinitis pigmentosa was present. The retinitis was noteworthy when viewed in the light of the suggestion that cerebral diplegia was syphilitic in origin. Dr. POYNTON mentioned a case of cerebral diplegia in the out-patient department which was getting progressively worse. Dr. HAWTHORNE asked for details as to the family history, and Mr. CARRÉ-SMITH as to the nature of the labour at the time of the birth of the child. Mr. LUCAS asked for information about the retinitis pigmentosa, and Mr. PERNET remarked that De Amicis, of Rio Janeiro, had placed on record several cases of retinitis pigmentosa in which syphilis was present in one or both parents. Dr. FENNELLS, in reply, said that the child did not begin to walk until three years of age. The family history was unimportant. No history of syphilitic taint could be obtained, and there was no history of nervous or mental disease. The labour had been a natural one.

Mr. H. S. COLLIER showed a baby the subject of a deformity of the shoulder girdle. It came to his out-patient room on the previous day. The deformity was similar to that shown in cases published by Mr. Willett. Mr. Collier also exhibited a process of bone which had been removed by him three years before from a similar case.

A paper was then read by Dr. WAYLAND CHAFFEY, upon a

#### CASE OF DIFFUSE LYMPHOMA

terminating in pernicious *anæmia*, occurring in an infant, *æt.* 11 months. When first seen the spleen and liver were enlarged. Examination of the blood showed no increase of leucocytes, the erythrocytes were 2,530,000, and the hæmoglobin 44 per cent. The child died after being in hospital twelve days. After death the liver, spleen, and kidneys showed the prussian blue reaction with hydrochloric acid and ferro-cyanide of potassium. Microscopic sections of the organs showed small-celled infiltration along the capillary blood-vessels, especially around the lobules of the liver. The CHAIRMAN remarked that the case was an example of a group of cases upon which much more light was needed.

Dr. LEES showed a case of a rheumatic enlargement of the heart in which brachial thrombosis had been present. Dr. SANSON remarked upon the prognosis of such cases and upon the causation of thrombosis in rheumatism. Dr. THEODORE FISHER also commented upon the thrombosis, and Dr. POYNTON, at the request of Dr. Lees, made some remarks. He said that thrombosis, associated with rheumatism, had attracted more attention in France than in England. It was much more common in children than in adults. In the fatal cases he had met with cultures from the clot had proved sterile.

*Double Facial Paralysis.*—Dr. HUTCHISON showed a

case of double facial paralysis due to middle ear disease. When first seen the child had double facial paralysis of a few weeks duration associated with discharge from both ears. Mr. Ballance cleared out the cells of both mastoid bones and recovery ensued immediately. The CHAIRMAN and Dr. SANSON commented upon the case, and Dr. HUTCHISON replied. Dr. HUTCHISON showed also two cases with congenital deformities. A boy, aged 4 weeks, with supernumerary digits, abnormalities of the feet, and congenital heart disease; and also a child, aged 16 months, showing a diffuse lipomatous *nævus*, a papiloma of the tongue, and congenital cataract. Dr. SUTHERLAND remarked that he had a case under his care similar to the first case of Dr. Hutchison, and thought it possibly a case of achondroplasia. Dr. HUTCHISON did not consider his case one of achondroplasia, but was open to conviction upon the point.

*Congenital Disease of the Heart.*—Dr. THEODORE FISHER showed two specimens of congenital disease of the left side of the heart. A case of mitral stenosis from a child, aged 15 months, and a case of aortic stenosis from a child, aged 4 months. The CHAIRMAN, until he had seen the first specimen, always felt convinced that congenital mitral stenosis did not exist, and stated that such cases must be excessively rare. Dr. SANSON considered that congenital defect of the mitral orifice was a myth, but thought that mitral stenosis occasionally was present, as in this case, as the result of intra-uterine endocarditis. Dr. NASH remarked that he had made an autopsy upon a case of congenital heart disease in an infant, aged 6 months, in which mitral stenosis was present. He proposed to exhibit the specimen. Dr. SUTHERLAND remarked that he had heard a mitral presystolic murmur in an infant, aged 18 months. Dr. THEODORE FISHER agreed that in previously recorded cases the stenosis appeared to have been the result of endocarditis. In his specimen, however, he could not understand how endocarditis could produce the fenestrated membrane which was present.

Other cases were shown by Mr. COLLIER and the CHAIRMAN. Mr. Collier showed a child with deformity of the hip-joints superficially resembling congenital dislocation. At three weeks of age the baby had suffered from abscesses in the neighbourhood of the hips. Skiagrams now showed separation of the femoral head epiphyses. The Chairman showed a girl who had suffered from arsenical neuritis, due to the taking of 15 m. of liquor arsenicalis three times a day for five weeks during treatment for chorea. Dr. SUTHERLAND, Dr. HAWTHORNE, and Dr. CHAFFEY remarked upon the case. The Chairman also showed the cast of a skull of a boy, in which very large nodules were present. Dr. HAWTHORNE remarked that nodules were now known not to occur only in acute rheumatism, but in rheumatoid arthritis also.

The meeting terminated with a vote of thanks to Dr. Lees for presiding.

### LIVERPOOL MEDICAL INSTITUTION.

The Opening Meeting of the Session was held on Thursday, October 10th, when the President, Mr. EDGAR A. BROWNE, delivered the Opening Address on

#### INTELLECTUAL PROGRESS AND GENIUS

After some prefatory remarks bearing on the work of the Institution, the President said:—To those who live in the midst of the most remarkable achievements of the intellect, the conditions of mental progress must be a fascinating subject, from whatever side approached. Whether we give ourselves up to mere wonderment, or to a picturesque enumeration of recent triumphs, or whether we endeavour to analyse the causes, the evolution and development of modern ideas, whether we take a historical view of the past, or endeavour to cast a horoscope of the future, whether regarded merely as an intellectual amusement, or as a practical guide for the organisation of our medical schools, or even as a help for the improvement of our minds, the interest of a general view of progress is likely to appeal to everybody. All travellers like occasionally to pause and view the road they have traversed, and examine

the map of where they are going. It would be wrong to take a survey of medical progress in a mere parochial spirit; our survey must be wide; we do not stand alone. There is no medical science properly so called; we are tied and bound by the condition of the collateral sciences on which we depend. We are opportunists, in the midst of our more precise brethren, taking from them what will serve our turn. But though we have no science we may claim a scientific method, which in its way is exact and productive of good results. The art of the practitioner must be distinguished from his science, his knowledge of the details of other sciences, from his appreciation, of what his own science requires. If we could carry out to its logical conclusion the scheme of a modern preliminary examination, *e.g.*, the matriculation of London, we should be not physicians, but scientists. The more exact a science, the less room for the exercise of art, and it is a union of the methods of scholarship and science with the personal skill in dealing with the half-seen and the obscure in clinical work that makes the practice of medicine so fascinating. But arts tend to be lost, and though science is more stable, not only sciences but civilisations themselves have disappeared. The Egyptians have gone; their learning was sufficiently profound to command the respect of the Greeks, but it has vanished. The modern Greeks are a brave and intelligent people, but they have not a tincture of the old civilisation; theirs is French. The possibility that modern science may be destroyed must be admitted, therefore the mode in which the torch of learning is kept burning or becomes extinguished is full of interest. There is nothing to show that in historical times the individual brain power has increased. The power of using it has; the increased power due to co-operation is enormous. We can only judge of the past by the remains of literature and architecture, and by those tests the ancient civilisations were raised by men fully our equals. The mental endowments of men have always been in three classes: men of genius, of talent, and the mediocrities. There is no sharp line of demarcation, as the characteristics may even be shown in the same individual under different circumstances. Genius can scarcely be defined, as it is manifested in many various ways. In relation to science it means the possession of faculties especially adapted for the work to be done. A man of genius may be supposed to have a feline quality of vision, able to pierce the surrounding gloom of ignorance earlier than others; hence have sprung the ideas which lie at the foundation of progress. Genius, however, is always of itself efficient, and the great value of the men of talent is as interpreters. They are capable of appreciating genius, of seizing the gist of new ideas, and bringing them into touch with the knowledge of the times. The mediocrities, of themselves, do not appreciate genius; they like it diluted; they herd together, they have their shibboleths, they distrust originality, singularity, or independence of thought. Thus they maintain the atmosphere of any art or science they may be connected with. They profit most by education, and they serve the practical purpose of diffusing and applying the knowledge afforded them by the men of talent. Now, if we fail in educating the mediocrities sufficiently for them to appreciate the teaching of the more active minds, the progress of knowledge is arrested, and science fails for want of diffusion. If genius fails, on the other hand, there is little use for the man of talent, and under such conditions science may dwindle, and even become lost. The inventive and research capacity of the Chinese must at one time have been considerable, but knowledge has not moved with them for 2,000 years; they have settled down to a vast population of mediocrities, occupied incessantly in passing examinations or examining others more mediocre than themselves. Appalling as the thought may seem, the possibility of the same thing occurring to ourselves if our educational machinery becomes perfected is not wholly chimerical. Moreover, a great discovery may be made and become public, but from a want of sufficient collateral knowledge may not only fall flat and be useless, but may even become positively detrimental; take, for example, the familiar discovery of the circulation of the

blood. There are various interesting points connected with the state of knowledge at the time it was made. Why was it not made before? First, it needed the establishment by Bacon, the protagonist of scientific thought in this country, of the inductive philosophy on the ruins of the ancient authority, especially that of Aristotle. Bacon found the physicians great offenders; he had a poor opinion of them, he said they reasoned in a circle, and doubtless he was right. But he gave them a serviceable map of the country; he said "Look the facts in the face, form your own opinions, never mind the ancients." Until that method was accepted as the working method, the passage of the blood through the arteries was not likely to be investigated because they were supposed to be air-passages. A few advanced thinkers knew that some blood was mingled with the vital spirits, but no connection with the veins was generally accepted. The liver, not the heart, was the prime motor, and when a thing was believed, and was obvious on superficial examination it took an original mind to look below the surface. Then it was a very unmechanical age, people did not concern themselves with the body as a machine—it was a vital organism, and a marvel, and not to be too rudely examined either. Then the collateral sciences were not ready. Oxygen was not discovered for more than 150 years. Before oxygen was discovered the knowledge of the mere paths of the circulation was no good; so instead of seeing that the central fact about the circulation was its connection with respiration, and accounting tentatively for the existence of the pulmonary tract, attention was merely confined to the movement of the blood—the movement, and not the reason for the movement—and therefore they bled. Thus the value of a great discovery was not only negated but perverted.

The address, which was listened to with great attention and delivered without the assistance of any notes, ended somewhat abruptly owing to want of time.

#### NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

MEETING HELD AT LIVERPOOL ON OCTOBER 18TH, 1901.

Dr. T. B. GRIMSDALE, President, in the Chair.

Dr. W. JAPP-SINCLAIR (Manchester) exhibited an improved portable apparatus for continual irrigation with fluid at a constant temperature, and explained its use.

Dr. T. B. GRIMSDALE (Liverpool) showed a specimen of cancer of the cervix in a uterus with three and a-half months' pregnancy. The symptoms had first declared themselves with the commencement of pregnancy. The uterus was removed successfully by vaginal hysterectomy.

CASE OF CANCER OF THE CERVIX.—OPERATION AND RECOVERY.—Dr. J. E. GRIMMELL (Liverpool) showed a uterus with four and a-half months' pregnancy and extensive cancer of the cervix, which he had removed by vaginal hysterectomy. Owing to the size of the uterus it had been found necessary after separating the bladder, to slit up the anterior wall of the cervix and uterus as far as the peritoneal fold, and through this opening to empty the cavity. The subsequent steps of the operation were easy, and the patient recovered and was reported well twelve months afterwards.

Dr. LLOYD ROBERTS (Manchester) showed a pair of large ovarian cysts with papillomatous degeneration removed by abdominal section. None of the cyst had burst, and the peritoneum had not become infected with the growths. There was no ascites, its absence being probably associated with the fact of non-infection of the peritoneum. The patient made a good recovery.

CASE OF CÆSAREAN SECTION TWICE PERFORMED.—Dr. W. JAPP-SINCLAIR (Manchester) related a case of Cæsaréan section performed for the second time in the same patient. The uterine wound was so intimately adherent to the abdominal wound that the new incision was carried directly into the uterus without opening the peritoneal cavity. The child was delivered through this opening. The patient was not sterilised by liga-

ture of the tubes or otherwise. Both mother and child recovered.

A discussion followed on the dangers of subsequent pregnancy after Cæsarean section had been performed, and on the question of sterilising operations under such circumstances. Dr. Grimsdale (President), Drs. Lloyd Roberts, Davies, Croft, Briggs, Garner, and Lea took part.

## Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, November 2nd, 1901.

THE *Munch. Med. Woch.*, 30/1901, contains an article by Dr. Lütjhe on

### RENAL DIABETES.

Klemperer was the first who pointed out the possibility of a renal diabetes. A discussion took place as to whether in that condition the passage of the sugar through the renal epithelium was passive, or whether the kidney actively sought out the sugar contained in the blood and excreted it. Such a question must be difficult to answer, and the fundamental question really is, Is there a diabetes in the human subject the cause of which lies in some disturbance of the parenchyma of the kidney? If an answer to this could be found our present knowledge of the pathogenesis of diabetes would be advanced a step. The positive material at hand from publications is very scanty, but theories are to be met with in abundance. The author relates a case which appears to be free from objection, and which answers all the requirements necessary for the postulate "renal diabetes."

The case proved the following: (1) absence of sugar before the appearance of the kidney affection; (2) appearance of sugar shortly after the commencement of the renal disease; (3) independence of the excretion of sugar on the amount of carbohydrates taken as food; (4) diminution of the quantity of sugar in the blood.

### INTERMITTENT HYDROPS ARTICULI.

A. Linberger has an article on this subject in the *Beitrag z. Klin. Chir.* The material employed in the compilation was met with in the Tübingen surgical klinik. The ætiological factor was in twenty-five cases rheumatism, in eight cases injury, then infection during the puerperium, gonorrhœa, malaria, tuberculosis, and intoxication, making a grand total of forty-nine cases. On the appearance of hydrops pain is never absent; when the cause is rheumatic there is usually pain, fever, some general disturbance, and of function, especially at the commencement. A chronic hydrops sometimes became an intermitting one, or the swelling continued a long time even in the periods between the attacks. Stiffening sometimes took place, with grating on pressure. Internal remedies were rarely of use, but the usual surgical treatment was generally successful. There was no constant relation between menstruation and hydrops, nor had the nervous affection any influence. Age and occupation had an influence in the origination of the disease. In most of the cases the author could determine that intermittent hydrops was a sequel of inflammation of the joint. The affection was not an independent one, but only a symptom of the most varied diseases.

At the Medical Society Hr. Th. Meyer showed a case of

### IODINE DERMATITIS.

The patient, a woman, had taken 22 grns. of potassic

iodide in ten days. The exanthem had spread very rapidly over a great part of the body in a very short time, especially the lower part of the face, the backs of the hands and thumbs, and both legs from the knees downwards. The smallest papules were a deep red with, in the middle, a small depression surrounded by a gray-coloured area. On the hands were vesicles, that later on became purulent, seated on a firm infiltrated red base. In one place was seen a blister the size of a two-shilling piece, which later on became purulent. The feet were similarly affected. Later on scabs formed. Syphilis was out of the question. The speaker drew attention to the observation of some French writers, who stated that under certain circumstances iodide caused exanthem of an erythematous or eczematous type, and also some of papulous form. The urine contained no iodine. Casts of the condition were shown, as well as photographs on the screen.

Hr. Stein, from Prof. v. Bergmann's Klinik, showed a laundrymaid with a

### SADDLE NOSE

That had been successfully treated by injection of fluid paraffin. The patient, æt. 14, had suppurating glands in the neck, which had been removed. In 1889 she fell down some steps, striking her nose and forehead, from which accident the saddle nose resulted. On admission into von Bergmann's klinik the condition was typical. There was no bridge to the nose, and the nostrils looked upwards. The patient naturally had a repulsive appearance. The results of the injection were excellent. The speaker related the history of this method of procedure from practice by Gersung, of Vienna, who first employed it on a man whose testicles had been removed for tuberculous disease, and who was refused admission to military service on account of the objectionable defect. The result in that case was satisfactory. Gersung then made use of the procedure in the case of a woman, æt. 29, who suffered from incontinence of urine. He injected a ring of paraffin around the dilated urethra, whereby the urethra was narrowed and the incontinence cured. Pfannensteil then tried to cure a case of incontinence in the same way, but failed, and a small embolism in the lung was caused. The case being published was the reason why the method was abandoned. Stern observed that the evil result was a consequence of the injection being improperly made, and that embolism may be avoided with certainty.

By permission of v. Bergmann the speaker had tested the method as to its safety in numerous instances on mice, rabbits, and dogs. The paraffin was not poisonous as he had injected one-third the body weight into an animal and it remained lively, but care must be taken to have the paraffin perfectly pure. If neither vein nor muscle was punctured the operation was perfectly safe. The paraffin should be passed into the subcutaneous or submucous tissue so that the overlying structures should be thrown into ridges. The paraffin in time got absorbed, but not before a growth of connective tissue had formed around and through it, which remained and made the result permanent. It had been found that hard paraffin softened in the connective tissue, whilst soft paraffin of the consistence of ointment at the end of a month had become as hard as cartilage. In the neighbourhood of muscles the paraffin was absorbed more quickly. His experiments had extended over a period of three months, and the parts then injected were still as hard as car-

tilage, especially those under the scalp; whilst another deposit, below the shoulder blade, had been partly massaged away by the action of the muscles.

## Austria.

[FROM OUR OWN CORRESPONDENT.]

Vienna, November 2nd, 1901.

### PSOROSPERMOSIS CUTIS.

AT the Gesellschaft der Ärzte Ehrmann presented a case of psorospermiosis cutis in the second generation. The father of the patient entered the Prague "Klinik" in 1892, under Janowsky, with a similar disease. The patient now exhibited entered hospital in 1896, with earth-coloured swellings on the skin of the groin, varying from a millet seed to the size of a poppy seed. These tubercles had a horny surface that could be easily torn off, leaving the horny epithelium in the folds of the skin. Under these tubercles were found finer granulated matter, with and without sheaths, which had formerly been the psorospermin, which now remained as a degenerative product of the epithelium. These tubercles have now become confluent, and formed a scurfy raw surface which has extended to the infra and supra-clavicular spaces, as well as patches on the scalp.

After the horny mass had entirely desquamated, the disease assumed the form of exudative eczema with ephelide pigmentation. In the inguinal region, probably owing to the maceration, the disease assumed the appearance of pemphigus foliaceus vegetans with a foul secretion and peculiar horny surrounding.

The disease may appear at a very early age, from three to five years and upwards, associated with scrofula. The internal use of cod-liver oil gives favourable results.

Neumann said the case was a very uncommon one, as hitherto no such case had been observed in Vienna. The diagnosis of the disease is the result of exclusion, as three other diseases closely resemble it, viz., lichen scrofulosum, which also has other local sites, as in psorospermiosis, but has smaller tubercles with a central depression and a lasting pigmentation. The small papulose of the syphilides arrange themselves also in groups arising from the hair sacs in the form of tubercles. There is also another form of disease, such as the common favus, that has a large number of reddish-blue tubercles, forming a scutulum.

Ehrmann related a similar case that had come under his notice a year ago, where a combination of lupus vulgaris and psorospermiosis were found closely united in the same individual.

### RUPTURE OF THE UTERUS.

Merzfeld next showed a preparation of the uterus which had ruptured before parturition. The patient was 38 years of age and had had seven children. In the tenth month of pregnancy severe pains commenced which were accompanied with vomiting. The bowels were confined, with a good deal of meteorism. The child's head was distinctly felt in the left side. After excluding all other complications, the diagnosis was arrived at that the uterus had been ruptured. Shortly after this peritoneal phenomena demanded operative relief. Under chloroform for the first time a large quantity of blood came away, which on closer examination was discharging

from a tear, two inches long, inside the neck of the uterus. Laparotomy confirmed the earlier conclusions; the child was removed through the rent, and the uterus and peritoneum carefully brought together. The woman died, notwithstanding every attention, through loss of blood.

Merzfeld presumed that the rupture had arisen in the first place from an old cicatrix in the uterus, probably from the curettement which had been performed after a former confinement. He warned the members against this operation, or any other instrumental interference in the uterus during the puerperal stage.

THE Provincial Diet of Upper Hungary has passed a resolution in favour of granting the status of medical practitioners to three peasants residing in a country village in virtue of the alleged possession by them of "miraculous powers" in the treatment of injuries to bones and joints. None of the three can either read or write; in fact they are nothing more nor less than popular bonesetters. Naturally enough the decision has excited the resentment of the medical men as a class, and a movement is on foot to obtain the rescinding of the objectionable and unprecedented authorisation.

## The Operating Theatres.

### MIDDLESEX HOSPITAL.

ABDOMINAL HYSTERECTOMY.—MR. ANDREW CLARK operated on a woman, æt. about 45, who was suffering from fibroids of the uterus, and whose life was rendered miserable by a constant desire night and day to micturate, the act being attended with considerable pain. After the patient had been anaesthetised, the usual incision was made from the umbilicus nearly to the pubes. It was found that the bladder projected considerably above the pubes, notwithstanding it being empty. The left hand was introduced into the abdomen, and no adhesions were found except in the neighbourhood of the left ovary; but there were sufficient to prevent the tumour being extracted from the abdomen until the incision had been extruded upwards some three inches to the left of the umbilicus. The bulk of the uterus was then drawn out, and it was found that there were several subperitoneal fibroids as well as a general enlargement of the uterus, these were drawn well over to the right side and without much difficulty the adhesions were separated and two or three bleeding points secured with ligatures. The ovary and Fallopian tube were then freely exposed and removed after a double ligature had been applied to prevent bleeding at either end. The tumour was next drawn over to the other side, and the ovary and Fallopian tube freed in the same manner; this enabled the whole uterus to be pulled out well on the abdomen, and a flap of peritoneum marked out and dissected up from the front; the uterine arteries were then seized with pressure forceps and divided and the whole of the uterus removed with scissors at its neck; silk ligatures were applied to the uterine arteries, and the flap of peritoneum sown over the uterine stump with a continuous suture, the parts having been first thoroughly treated with a perchloride of mercury solution (1-4000). The pelvis was mopped out, and the abdominal wall brought together layer by layer with a continuous suture. The wound was dressed and the

patient removed to the ward. Mr. Clark remarked that there were certain conditions under which hysterectomy was not only desirable but necessary; namely: 1, when a tumour had attained such a size as to produce serious inconvenience on that score; 2, when it was rapidly growing; or 3, when from its presence by pressure or otherwise, it produced troublesome symptoms, and although there were some of these cases in which oophorectomy might be practised with a view of arresting the growth or diminishing the size of the tumour, such was not likely to be of service in a woman about the time of the natural menopause; moreover, hysterectomy was a more certain cure, and now that it had become such a safe operation it was generally preferred. The reason for submitting this patient to the operation was the trouble produced by pressure on the bladder, and here the dilated bladder rather interfered with the incision, which would have more conveniently been extended downwards instead of upwards. He further remarked that this was a good specimen of the three varieties of uterine fibroids: (1) the subperitoneal, (2) the intra-uterine (for on opening it two polypoid fibroids were found in the uterine canal), and (3), perhaps the commonest condition of all, the general enlargement of the uterus itself. The second of these three was not expected, as intra-uterine fibroids are usually attended with menorrhagia, and this woman had never suffered from this; indeed, she stated that from the age of 14 she had been absolutely regular in her monthly periods, even to the day. Mr. Clark pointed out that he had used the continuous suture throughout in this operation, and he did so because of the rapidity with which it could be applied, and although speed was not of supreme importance in operations nowadays there are cases, and particularly abdominal sections, in which the patient becomes considerably collapsed after a time.

Ten days after the operation the patient had progressed without any unfavourable symptoms, except that she had been, and was still, unable to pass her urine, and had to be relieved by a catheter.

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## The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, NOVEMBER 6, 1901.

A NATIONAL CONCERN.

THE theory of air-borne typhoid as contrasted

with water-borne typhoid in armies, to which Dr. Leigh Canney recently directed public attention, involves questions of extreme importance. The author bases his deductions mainly on the reports of the Army Medical Department. In the case of India and South Africa he has selected those of the years 1897 to 1899, and for Egypt those of 1884-1887 and 1898-99; he also brings forward facts he has himself observed while in private practice in Upper Egypt during the past ten years. That Dr. Canney is not an advocate of the air-borne theory is seen from his experience at Assouan. He notes that while 8,000 English and American visitors spent a great part of the winter at that place, and swallowed quantities of dust, only four developed enteric last winter, and that this is the usual proportion for previous winters. He does not, however, make any statement for the summer months, which necessarily must be more important, as it is at this time the British troops stationed at that place suffered most. Dr. Canney, however, states that “wherever the British Army or other Army has gone it has either taken enteric germs with it (with rare exceptions), or it has managed to fix on some of the worst camp sites, with no suitable protective methods. When the disease appeared army methods were rarely timely, adequate, or comprehensive enough to command success.” The protective methods of the Army against enteric are, in the main, the points to which Dr. Canney desires to draw attention, and he suggests the formation of a Royal Water Corps. In a previous issue, we have discussed this proposal and the objection to the use of petroleum and sterilizers. We pointed out the grave risks of the vicinity of such a volatile explosive when accompanying ammunition, more especially in a country like South Africa where grass fires are of daily occurrence. We also alluded to the fact that exception would be taken by military authorities to the transport of such fuel, of the sterilising apparatus, and of its accompanying refrigerators, as it would necessitate more mule transport in a regiment than is at the present allowed for ammunition. With regard to the formation of a Royal Water Corps on the lines suggested by Dr. Canney, the idea is not new. It was adopted in the Natal Army by General Buller’s principal medical officer, Sir Thomas Gallwey, and has probably been adopted in other parts of South Africa. In our issue of August 28th last we published an article on this subject by Lieutenant E. Blake Knox, M.D., R.A.M.C. In it, the ætiology and prophylaxis of water-borne diseases, more especially enteric, are discussed. Had Dr. Canney referred to this officer’s statements of the prophylaxis followed, at any rate by the Natal Army if not also by other columns, it is very doubtful if he would have made the following assertion. He says, “Pure water—the one important thing in war—is practically no man’s business in the Army; water polluted with enteric, dysentery, and diarrhoea organisms is still drunk every day in South Africa.” We all fully

recognise that sanitary reform is open to improvements in the Army. The recent warrant proposed by the Army Medical Service Committee has also recognised this in its recommendations. We should regard as a practical scheme in this respect the appointment of a special sanitary officer, with a few men, to every division in the field, or home district, whose sole duty and responsibility would be the selection of camps and their daily sanitary inspection, the selection and allotment of available water supplies—marking one for human consumption, one for washing, and one for animals—and the supervision of the disposal of refuse and disinfection of excreta. Further, in order to assist and co-operate in sanitary matters with this officer, a special committee should be formed in each district or camp, including the Provost-Marshal and an officer of the Royal Engineers. The combined men serving under this committee would furnish police and fatigue parties sufficient to enforce strict attention to all matters connected with the sanitation of the camp. Any breach of discipline pertaining to sanitary matters would be reported by the police to the committee and dealt with by the latter. We are of opinion that the problem raised by Dr. Canney is a serious one, and that it can only be faced with a hope of success when the Army shall be educated to its vital importance. Medical men and water corps such as Dr. Canney suggests are next to useless unless all officers, non-commissioned officers, and men, are taught the elements of sanitation. In this lies the keynote of success.

#### THE NOTIFICATION OF PHTHISIS,

WILL tuberculosis ever be stamped out of our midst? The answer to that question would probably be in the affirmative from all who are acquainted with the history and the methods of preventive medicine, which in its way may be regarded as the most progressive of all branches of medicine. Of recent years the mind of the nations all the world over has been exercised upon the great problem of the prevention of phthisis. The great impetus to the modern study of the disease was undoubtedly due to the discovery of the specific bacillus of the malady by Professor Koch, in the year 1882. The subject has now become part of the stock-in-trade of the popular journalist, and it is almost impossible to find an ordinary newspaper of any importance that does not contain a reference to the matter. The curability of consumption, indeed, is now everywhere recognised as an established fact in scientific medicine. Further, it is recognised that there may be various methods of cure, while no specific has hitherto been discovered. At the same time, it is impossible to admit the claims of the thousand and one so-called "cures" that are placed daily on the market by persons who seek either advertisement by notoriety, or mere sordid pelf through the agency of advertisement. There are not a few Gordian knots

in the causation and the prevention of tuberculosis that have still to be unravelled or cut before success can be attained. A crucial problem, for instance, was raised by the theory advanced by Koch at the recent London International Congress, namely, that tuberculosis was not communicable from the lower animals to man. In the answer to that objection lies the key to the effective organisation of our public sanitary service as regards phthisis. If tubercle cannot be conveyed by infected flesh and milk then it will be useless to control butchers and dairymen, so far as the spread of tuberculosis is concerned. If, on the other hand, the specific *bacillus tuberculosis* of the lower animals be communicable to man, then the greatest hope for future generations almost certainly lies in the rigorous supervision of food supplies. In the United Kingdom the trend of general scientific opinion has of late years been strongly in favour of the identity of human and comparative tuberculosis. Some years ago Klein found that guinea-pigs kept in the ventilating shaft of Brompton Hospital became tuberculous. Some quite recent experiments by Professor Délépine in this country point to the infection of lower animals by human tuberculous sputum. The latter observation, however, cannot be accepted as absolutely conclusive, owing to the fact that the tuberculin test for existing tuberculosis was not previously applied to the animals experimented upon. But whatever the upshot of the investigation of this point that is now being carried on vigorously on both sides of the Atlantic, the infectiveness of the phthisical human subject has not been called in question. All measures, therefore, which are directed towards the limitation of the disease in man, apply with equal, or rather with much greater force, even were the truth of Professor Koch's paradoxical theory demonstrated. From this point of view we are brought back face to face with the practical sanitarians, the medical officer of health, his inspectors, and his disinfectors. Needless to remark, one of the great weapons wherewith communicable diseases have been brought under the control of sanitary authorities is that of compulsory notification. The first step in the scotching of infection is to be able to locate and attack the centres of infection as they arise. Can this be done in the case of tuberculosis? The recent Congress in London recorded their approval of voluntary notification, and it is not surprising that a great representative body of that kind should adopt a somewhat cautious attitude in approaching a matter that affects the material and social interests of the community to no small degree. At the same time it may be urged that the law has recognised the right of local authorities to control the individual in the case of other communicable diseases. Moreover, that supervision has been exercised without friction with the medical profession and with vast benefit to the community. To be content with the notification of deaths from phthisis to the



medical officer of health is to deal with the effect and to pass on the other side of the road so far as the essential cause is concerned. The rooting out of tuberculosis appears to demand some form of notification of the disease upon grounds that have already been recognised by the Legislature. The exact form of the notification will have to be carefully considered and determined upon before many years have passed, otherwise the discoveries of science and the efforts of preventive medicine may be stultified, and the attainment of the ultimate goal of eradication may be indefinitely postponed.

#### DEGREES FOR LONDON STUDENTS.

DIPLOMATES of the Conjoint Board of the Royal Colleges of Physicians and Surgeons have recently been circularised with the object of forming an association to be termed the London Licentiates' and Members' Society. The aims and objects of this embryo association are set forth as follows:—1. To petition the Royal Colleges. (a) To obtain powers to grant degrees; (b) or in the alternative to join with the University for the same object. 2. To request the Royal College of Physicians to rescind their by-law prohibiting their Fellows, Members, and Licentiates from using the popular title of "Dr." For some years past scarcely an opening address has been delivered at the medical schools without the solemn assurance being given by the orator that the question of degrees for London students was occupying seriously the consideration of the "authorities," and that "something was sure to be done during the ensuing year." This farce has continued for so long that it was becoming almost a time-honoured joke, and was beginning to be warmly welcomed as an old friend by October audiences. Now, however, it seems to have fallen, as have many of the introductory addresses themselves, into disuse. The proposed society, however, shows us that, in a certain section at any rate, the question has not been allowed to drop. While admitting the justice of the grievance which the London diplomates put forward, we gravely doubt whether the objects given as forming the plan of campaign of the society are likely to obtain their wish, or, indeed, to do more than again bring attention to the fact that there is a grievance. To commence with, the first suggestion is to petition the Royal Colleges to obtain powers to grant degrees. It is stated that in 1887 the Royal Colleges of Physicians and Surgeons determined to endeavour to obtain powers to grant a degree on the same standard as the then granted diplomas. We do not recall what steps these bodies took, but that their endeavours failed is evident, since nothing has been done in the matter during the fourteen years that have elapsed since that determination was decided upon. Moreover, we do not see how corporate bodies which are not universities can, however powerful they may be, obtain such powers in the face of the strong opposition which the established universities would raise to combat what could only be considered as an infringement of their particular rights. The alterna-

tive is that the Colleges should join with the University (we presume that of London) for the same object. Here again we do not see, when the regulations of the Colleges and those of the London University are compared, how this is to be accomplished. It would mean great changes on the side of one or both, changes of a radical nature. Existing graduates of London University could not but object to any change that would make the degrees they hold easier to obtain, whilst intending diplomates might grumble at having to face a more stringent examination than their predecessors. The suggestion that the Royal College of Physicians should be requested to rescind its by-law regarding the title of "Dr." appears to us to be equally impracticable, for the use of such a title without the holding of a degree giving the right thereto is not merely a question for the College. Lastly, some provision would, were the objects of the suggested society attained, have to be made in the case of Fellows of the Royal College of Surgeons and Members and Fellows of the Royal College of Physicians. Granting, for the sake of argument, that diplomates of the Conjoint Board were to become entitled to some degree, say an M.B., B.S., then the F.R.C.S. and M.R.C.P. or F.R.C.P. would have to carry with them a higher rank, say an M.S. or M.D. respectively. Therefore, whilst we are fully in sympathy with the London diplomates in their grievance as to the hardships and disabilities under which they suffer in this question of degrees, we cannot but think that the proposed line of work suggested by the London Licentiates' and Members' Society is impracticable and not calculated to arrive at any satisfactory solution of the problem. To our minds the only possible way out of the difficulty is the formation of a teaching University for London, in the accomplishment of which, judging by the want of progress during the years which have elapsed since the subject was first taken up, there are numerous obstacles to be surmounted.

#### Notes on Current Topics.

##### The Health of the King.

OUR article on this subject in last week's issue has had the desired effect, which was to obtain an authoritative contradiction of rumours which have of late been persistently current on the Continent and in certain circles in this country. It is with unalloyed pleasure that we receive the assurance of the baselessness of the statements put forward with such circumstantial plausibility. The publicity given to this authoritative contradiction will dissipate a feeling of grave anxiety which was gradually gaining ground in the absence of an official statement. One reason why such rumours obtain more or less ready credence is no doubt because past experience has led the public to suspect that it is often left in ignorance of events of the highest importance until secrecy is no longer possible. We congratulate ourselves on having been the means of

removing this source of anxiety by eliciting a satisfactory assurance of the excellent state of his Majesty's health.

#### The Negro Question in America.

THE negro question in America has been again brought prominently to the front by the action of President Roosevelt in accepting a distinguished member of the coloured community as his guest. This step on the part of the head of the United States' Government has, we understand, caused a perfect storm of indignation and disapproval, an outburst which we in England have a difficulty in understanding, for with us the prejudice against the coloured races, although scarcely non-existent, is faint. The question with which our cousins across the Atlantic will soon be confronted is one of immense importance to them, and is, again, one which it is impossible for an Englishman to realise. The unquestionable superior fecundity of the negro is resulting in a great numerical increase in the coloured population of the States, especially in those of the southern portion of the continent, where climate and other circumstances are markedly advantageous to the black race. This fact, together with the probability of a limit being put to the influx of alien whites, a point which is seriously engaging the United States' Government at the present moment, threatens the white population with the possibility of a future superiority of the black population, a possibility which may, perhaps at no very distant date, require all their energies to meet it. We cannot, however, imagine that such a contingency would ever become of a more serious nature than frequent negro revolts, with occasional massacres of whites, for, despite the hysterical drivellings of a certain class of people, the black man never was and never will be the white man's equal. "Am I not a man and a brother?" was a frequent and favourite question in the time when the question of slavery caused so much bloodshed between men who should have been united, and were that question asked of us now we should return an emphatic negative. Taking the white man to be the—at present—highest development of the species, the African negro is intellectually far behind him. Speaking from the point of view of the development of races, the negro is still in his infancy, and he must pass through many generations before he can have sufficiently corrected his facial angle and increased his cranial capacity to enable him to compete with the superior white. That certain members of the negro population have attained to some degree of eminence in the various vocations and professions of civilised life is true, but they are but the exceptions—the isolated instances; we doubt if they could be considered as the "vortrekkers" of a coming race. It is this inferiority which lends an element of security for the white in the future relations of the two races in America. That an overwhelming superiority of numbers would in the end lead to trouble cannot for one moment be doubted,

but, until that event were accompanied by equality or superiority of intellect, it could never lead to the negro becoming the predominant race.

#### The Bacelli Treatment of Foot and Mouth Disease.

IT is not often that a Minister of Agriculture poses as the discoverer of novel methods of treating the diseases of animals, but Signor Bacelli's name is well known in connection with the carbolic treatment of tetanus—a method which is still upon its trial. Proceeding on very similar lines he now advocates intravenous injections of perchloride of mercury as a cure for foot and mouth disease. If the statistics are to be believed, the results are little short of marvellous, but we feel bound to maintain an attitude of reserve in respect of experiments made at the instance of a Minister, himself the inventor thereof. Foot and mouth disease is sufficiently prevalent for confirmatory experiments to be made forthwith in abundance, and we shall await the results of the treatment in independent hands before formulating a definite opinion as to its value.

#### The Medical Officership of the London School Board.

THE circumstances attending the resignation of Dr. William R. Smith, who for upwards of ten years has filled the post of Medical Officer to the London School Board, are sufficiently instructive to deserve some consideration. When the post was created candidates were invited to compete under certain conditions, one of them being that he should devote the whole of his time to the duties of his office, and that he should not hold any other paid appointment. Dr. Smith was selected from among a large number of candidates, and the first thing the Board did was to abrogate this condition in his favour, he receiving permission to remain in possession of certain other posts then held by him. We protested against this course at the time, on the ground that it was unfair to exclude possible candidates by insisting on a very onerous condition, only to waive it in favour of a particular candidate. Since that time Dr. Smith has discharged the responsible duties of his position with assiduity and, as far as we are aware, to the satisfaction of the Board. The remuneration attached to the post is £600 per annum, obviously a wholly inadequate salary for a man of the standing and experience required for the duties and responsibilities imposed upon him. Some time since Dr. Smith applied for an increase of salary, and after several discussions the Board rescinded a resolution increasing the salary by £200 per annum, and required Dr. Smith to accept the £600 for a year, he continuing to hold his professorship at King's College, and failing his acquiescence, to receive six months' notice. As Dr. Smith did not see his way to complying with the Board's conditions he sent in his resignation. Now we cordially concur in the view that the Medical Officer to the London School Board ought not to hold any other paid appoint-

ment, the duties of the office offering ample scope for the most indefatigable workers; but it is unjust to impose this condition unless the salary be made commensurate with the dignity and responsibility of the appointment, which obviously six, or even eight, hundred a year is not. The Board will have no difficulty in finding candidates for the vacancy created by Dr. Smith's retirement; but if they succeed in obtaining the services of a really capable man they will have to raise the rate of remuneration, or he will, after a time, follow Dr. Smith's example. In the interest of the community ruled by the Board we trust this view will receive due consideration. A capable man can render inestimable service, but he is not likely to throw his whole soul into his work unless he can rely upon receiving more generous and considerate treatment than has been meted out to the present holder of the post.

#### Domestic Filters.

DR. JOSEPH PRIESTLEY, in a letter to *The Times* of October 26th, draws attention to the need for a standard for domestic filters. He remarks "that a need exists for domestic filters as a thorough protection against water-borne disease must be admitted when we trace a water supply from its source, through its storage and distribution, and see the many different points at which infection may take place." Sand filtration, which is generally used at water-works, although theoretically correct, was found wanting in the cholera outbreak at Altona. Infection may occur in the mains, either from hydrants and fittings, or leaking from defective joints. Analyses of the same water made at different points seldom agree. As regards filters, experiments made at the laboratories of the College of Physicians showed that filters depending on charcoal, asbestos films, spongy iron, magnetic oxide, &c., were all more or less inefficient, using the term "efficient" as meaning the power of arresting disease germs. Some filters were even found to add germs to the water. Only two filters were shown to arrest germs, the "porcelain" and "infusorial earth" filters. The former, known as the Pasteur-Chamberland, is made from a specially prepared porcelain. It was used in the French Army when enteric fever was prevalent, and is said to have caused immunity against the disease whenever used. Since the Pasteur-Chamberland filter the Berkefeld has been introduced, depending on infusorial earth. This has also proved efficient. There is, however, a difference between the two filters, as shown by experiments at the Netley Laboratory. Typhoid bacilli were found to penetrate the infusorial earth in a few days, but failed to penetrate the Pasteur-Chamberland. These experiments were exhaustive, and conducted with polluted and unpolluted waters, to which typhoid bacilli were added, and waters with or without the addition of nutrient broth, ensuring all possible conditions. These conditions were necessary, as it is known that bacilli do not grow equally in all waters, and not necessarily in the most polluted waters. Dr. Priestley concludes with pointing out the necessity for increasing the

standard of efficiency for domestic filters, and to make them able, not only to filter germs, but to permanently avert them. He, therefore, recommends the Pasteur-Chamberland filter as the only one which fulfils this high standard. The Berkefeld filter was used in the South African war, and did not prevent enteric fever. However, Tommy Atkins when thirsty, does not wait for his water to be filtered.

#### The General Medical Council Election.

THE date is approaching (November 21st) ere which the nomination of candidates for seats on the Council must have been filed. There are in the field five candidates for the two seats left vacant by the retiring members, Dr. Glover and Mr. George Brown. These two gentlemen offer themselves for re-election. The other candidates are Dr. S. Woodcock, a prominent member of the British Medical Association in the north, Mr. George Jackson, of Plymouth, and Dr. C. Hayward, who appears to be attached to the Hahnemann Hospital at Liverpool, and may be assumed to come forward as a representative of the homœopathic practitioners. We have from time to time published the addresses of the various candidates from which our readers will have been enabled to form opinions as to their respective suitability. It is imperative that in selecting their representatives, practitioners should take care to choose men with definite views on the questions which press for solution, men, moreover, who will be able to urge these views on the Council in a manner calculated to commend them for adoption. In view of the widespread interest which is taken in matters bearing on medical reform, we may hope that a larger proportion of medical men will take the trouble to register their votes than has been the case at previous elections. In Scotland, Dr. Bruce, the retiring member, presents himself for re-election, but he will be opposed by Dr. Charles Robertson, of Glasgow, and Dr. Norman Walker, of Edinburgh. In Ireland, Sir Wm. Thomson will, so far as we are at present aware, offer himself for re-election. We have not heard of any opposing candidates.

#### A Pertinent Question.

"TRUTH" calls attention to a curious concatenation of circumstances which certainly appears to call for some explanation:—"In the correspondence columns of a weekly paper a few weeks back some one signing himself 'L. P.' inquired after a cure for bronchitis. In the following week another correspondent signing himself 'W. P.' of 255, Peckham Rye, answers that he has been cured and will be glad to forward the name of the doctor who cured him and a pamphlet written by that individual. A sufferer from asthma writes to 'W. P.' and receives from him a pamphlet written by G. A. Macnutt, M.D., M.R.C.S. Eng., L.R.C.P. and L.M. Edin., and inscribed with the author's address, 21, Leinster Square, London, W. In a covering letter 'W. P.' assures his correspondent that he knew nothing whatever of the correspondence in the paper until it was sent to him, testifies to his joy and gratitude at his delivery from lifelong suffering,

and concludes thus:—If Mr. B. will send Dr. M. a full statement of his case, Dr. M. will tell him whether he can treat him at a distance; or, still better, perhaps Mr. B. will come for a personal interview." It would be interesting to know how "W. P." came to be possessed of Dr. Macnutt's pamphlet for distribution; indeed, in the absence of explanation, the case savours strongly of an occult method of advertising which is very much to be deprecated. We may assure our contemporary that such a method is not "recognised as legitimate," though it may for obvious reasons be very difficult to suppress.

#### The Advertisement Craze in High Places.

THE craze for notoriety, which, in the following connection, is merely another name for advertisement, among Continental professors and leaders of medicine has developed a fine art of its own. Not only the medical profession in the United Kingdom, but the general public also are continuously exploited in favour of this new cure, of that synthetic drug of great price and indescribable virtues, or of something or other curative that is calculated to bring custom to chemists and patients to consulting rooms. Not infrequently the news of the great discovery flashed round in the world in pithy telegrams conveys some fallacious and exploded theory, or some silly paradoxical or quack speculation—in other words, a lie. It is said that a Vienna professor, more candid than his fellows, when asked recently how they were getting on in that part of the world, replied, "Oh! we are getting on excellently well, as Bismarck used to say, by publishing lies." The evil is not altogether unknown within the sea-girt shores of our own tight little island, especially now that some of the leaders of the profession carry on discussions in the newspapers about drugs of which they confess they know nothing. The Americans have cut the Gordian knot by allowing everyone to advertise all round, a latitude of which the restless Yankee medico avails himself to the full. Their method has, at any rate, the advantage of complete candour, for the stringent unwritten rules of the medical profession in the United Kingdom are over-ridden roughshod by those who sit in high places. They have not yet, however, sunk to the level of the systematic advertisers among the Continental professors.

#### The Plague at Liverpool and Glasgow.

ONE of the indirect risks from the South African War is the great amount of infection, chiefly enteric, that is being brought home by the shipload. Now that the plague has been added to the other dangers of the situation, the chances of infection of our home ports has been greatly enhanced. It behoves the port sanitary authorities, therefore, to keep their watch upon ships coming from the Cape with unwearied vigilance. The plague has recently obtained a footing in Liverpool, as officially testified by the Local Government Board. It appears that some half-dozen cases of illness occurred in that town about the end of September, and they were sup-

posed to have been due to influenza. Later, some doubts having arisen as to the real nature of the malady, bacteriological tests were applied, and it was found that two of the patients had died of bubonic plague, while three other cases were doubtful. The mother of two girls engaged in a Liverpool drapery shop returned from Glasgow, and shortly afterwards sickened and died. Her daughters were taken ill, and one died. The woman who attended to the bodies became ill and died, as well as three of her children, while a fourth is still in hospital. Other cases of infection are suspected. Immediately on the heels of this intelligence comes the news of an outbreak of plague in Glasgow. Several patients have been removed to hospital from a leading hotel in the city. It is supposed that the infection was conveyed by rats. The attacks are said to be in no way connected with the cases reported about a fortnight ago to have been brought into the port in the Anchor liner *Batavia*. In that case it points to a recrudescence of a former attack, and points to a widespread distribution of the bacillus. It is not stated whether the Liverpool sufferers visited the infected hotel at Glasgow, or whether they contracted the disease elsewhere in the latter town. In spite of the fact that recent experiences seem to show that plague cannot become established in the United Kingdom under modern sanitary conditions, the invasion of a great centre of population must, nevertheless, be always regarded with a good deal of anxiety.

#### Anglophobia in Continental Health Resorts.

THERE can be no doubt that one of the unpleasant results of the present war at the Cape has been a widespread awakening abroad of the fierce unreasoning hate of all things British. So blind to their own interests are the residents of some of the Continental health resorts that a correspondent to a London newspaper has solemnly warned both doctors and their patients as to the reception awaiting them abroad. As regards Davos, he writes that "the anti-English campaign has been carried on with a coarse savagery that renders the place unfit for invalids." Really it is time that the medical profession of the United Kingdom took to ordering their patients to the excellent spas and seaside watering places in our own islands. Springs like those of Bath, Harrogate and Droitwich are unsurpassed by any Continental spas. All that is wanted is for them to be made fashionable by the combined patronage of Royalty and of the consultant physicians. It is matter of common knowledge that the Germans regard with unmixed astonishment and contempt the custom of English medical men in sending off their patients, curable or incurable, to places away from their own country. As to consumption cures, there is no need nowadays to go to Davos or any other foreign resort. In the United Kingdom there is abundant choice of the purest air and the finest scenery of its kind in the whole world, and the consumptive is more likely to recover amidst native surroundings than in the midst of strangers, whose

only interest in him is a pecuniary one. Besides, many of the high-altitude resorts are saturated with tubercle bacilli in dwellings, hotels, laundries, and every other point of domestic environment.

#### An Action Against a Medical Man.

A CURIOUS case of alleged malpraxis came before the Recorder of Dublin the other day. It is one which well illustrates the difficulties attending the diagnosis of certain forms of injury to the shoulder, and also the degree of gratitude which a medical man may expect to receive from a certain class of patient, A Mrs. O'Reilly, the wife of a teacher and librarian at the Mountjoy Prison, on February 22nd last, received a serious injury to her shoulder as the result of a fall downstairs. On the following morning she consulted Dr. Dowdall, the Medical Officer of Mountjoy Prison. Her arm was then considerably swollen and after careful examination he recommended her to go to the Mater Hospital. However, as the patient said that she would prefer to be attended in her own house, he recommended her to foment the arm and shoulder with hot water and poultices. On April 1st she went to the Mater Hospital, where she was attended by the Assistant Surgeon, who told her that her shoulder was dislocated. She remained in the hospital about a fortnight, and came back on June 1st. By the use of the Röntgen rays it was found that beside dislocation there was an impacted fracture of the shoulder. The plaintiff complained that if this injury had been discovered and treated at an earlier period she would have been spared much pain and suffering, and the evil effects of the accident. The medical evidence of Mr. Blaney, the Hospital Assistant Surgeon, and of Dr. Myles, President of the Royal College of Surgeons, who was called on behalf of Dr. Dowdall, was to the effect that, even if the diagnosis of a dislocation had been made in the first instance, it would not have been advisable to attempt the reduction of it on account of the complicating impacted fracture. The result of the action was, as might be expected, to completely vindicate the defendant. The following words of the Recorder are clear, and very much to the point; we commend them strongly to the attention of the general public, who consider that not only is a medical man to do everything for nothing, but that he is to be punished for every error of judgment made whilst doing so. He said: "Doctors can only be held liable for mistakes caused by negligence, and not for errors of judgment. In my opinion the poorer classes are so absolutely pampered with medical assistance that anything like grace or gratitude to the medical profession had absolutely gone from them. In this case the patient was attended free by a skilful medical man in her own home, because she was the wife of a prison official, and would not go to hospital, as she was recommended to do. Was it fair for her now to bring this gentleman into public court, and arraign him as if he had done something wrong? Dr. Dowdall leaves the court without the slightest imputation on his medical escutcheon."

#### The Mosquito Campaign in West Africa.

MAJOR DONALD ROSS delivered an interesting lecture at Liverpool on October 21st to the West African Trade Sections of the Liverpool Chamber of Commerce, in which he recounted the various steps which are being taken in different portions of the West Coast to bring about the discomfort of the mosquito. It is pleasant to learn that he has returned from a tour round the most important settlement satisfied that reform in sanitary matters was taking place, and that the Governors of the coast were doing all in their power to further it. Major Ross is a strong advocate of radical measures of reform. He approves of the adoption of such precautions as the general use of quinine, the segregation of Europeans, and wire-gauze protective screens for the entrances and windows of houses; but he considers that the really important step is the drainage of swamps and the breeding pools of mosquitoes. In answer to the criticism that it is impossible to entirely eradicate mosquitoes, Major Ross says that such a proceeding is not proposed. An attempt is being made not to destroy every mosquito in Africa, but to reduce their numbers in towns by doing away with their innumerable breeding places. The speaker also called attention to the effect which greater comfort had in maintaining health, and contrasted the condition of Europeans in Calcutta with their condition on the West Coast. He believed that if private subscriptions were forthcoming to pay the initial expense of "settlement farms" and other improvements, the Government would help. The two great watchwords for the improvement of health on the West Coast were—"No stagnant water, and greater comforts for Europeans."

#### Proposed Coronation Gift to the Hospitals.

As Prince of Wales, King Edward showed his deep interest in the London hospitals by the inauguration of the hospital fund which bears his name. It is evident that in his elevation to the Throne our Sovereign has not forgotten his charitable schemes, and, just as he endeavoured to free the hospitals from embarrassment to celebrate the Diamond Jubilee of his illustrious mother's glorious reign, so he is now hoping to similarly mark his own accession. The Committee of the Prince of Wales's Hospital Fund have issued an appeal to the charitable public to provide a sufficient sum, by way of a Coronation gift, to free the London hospitals from financial embarrassment. There can be no doubt that such an appeal, if successful, would result in much help to the suffering poor for whom the hospitals are really intended, but we should like to see some more stringent means taken than heretofore to prevent the gross abuse which exists of this form of charity. There is ample necessity for increased hospital accommodation among the really poor, and the raising of money by such an appeal as we have mentioned would enable some 450 hospital beds, now closed for want of funds, to be reopened. To our minds, however,

the important question to be asked is:—Would these beds be occupied by the patients who are in most urgent need of them? Or would they be filled by those who are perfectly able to afford to pay fees for proper medical attendance? This a matter for the Fund officials to carefully and seriously discuss, for much might be done to regulate hospital abuse were these authorities to formulate a series of rules which would settle the question as to what is and what is not abuse, and to refuse aid to all institutions which did not agree to stand by such rules. In formulating any series of rules of this nature it must be remembered that abuse of general and special hospitals is so widely different that they must be considered separately. The person who can well afford a half-crown fee, but seeks aid at a general hospital for a trivial ailment, abuses that charity; but the same person who seeks the aid of some special hospital, we will say for an affection of the eye, does so with perfect right. Such institutions are provided for the relief of those who cannot pay the high consultation fees charged by specialists, and, therefore, a totally different class of patients resorts thereto.

#### Quacks and their Fees.

A CASE which presents certain points of interest was tried the other day at the Kirkby Lonsdale County Court. Dr. Wearing, of Clapham, Yorks, sued a railway guard named Nash for £2 12s. for attendance on the defendant's son. It appeared from the evidence that Dr. Wearing first saw the case in February, 1900. The child had then been limping for three months. There was marked eversion, external rotation, and flexia of the right hip-joint. The doctor at once diagnosed hip-disease. By rest in bed and extension the limb was got into good position and the pain ceased. A hip Thomas was then applied and the patient allowed to go about on crutches. In January, 1901, a fluctuating swelling appeared over the front of the hip joints, and Dr. Wearing advised the parents to let the child go to a hospital. Instead of doing this, however, they took him to a man in Lancaster, who described himself as a herbalist. This worthy told them that the joint was "out," and that there had never been any disease. He gave them something to rub it with, and then, having taken a fee of £2, sent them to a bone-setter. He concurred in the diagnosis of his friend the herbalist, manipulated the hip, and was paid ten guineas. The father subsequently refused to pay Dr. Wearing's account, alleging that he had treated the child for hip disease, whilst all the time it had been suffering from a dislocation. Dr. Mackenzie, of Ingleton, saw the child once, just before it was taken to the herbalist, and confirmed Dr. Wearing's opinion. Mr. A. S. Barling, Surgeon to the Royal Lancaster Infirmary, was also put in the box. He said that he had heard the evidence, and there could be no doubt that the case was an ordinary one of hip disease. Being asked by the Judge to explain how it was that the child seemed to have been benefited by the bone-setter's treatment if there was no dislocation,

Mr. Barling said that in these cases there was always some stiffness of the joint due to adhesions, and bone-setters always said they were dislocations and took credit for reducing them. The boy was in court walking with difficulty with the aid of a stick. The parents refused to accede to the Judge's suggestion that Mr. Barling should examine the child. In giving judgment for the plaintiff, with costs, the Judge said that the case was undoubtedly one of hip disease.

#### The Ventilation of Tubular Railways.

A FEW weeks since we criticised the ventilation of the Central London Electric Railway, and pointed out that it would be in the future interests of the large towns of the United Kingdom to detect and remedy defects in that direction. It appears that for some time past Professor Wynter Blyth has been making experiments on the air of the tunnels in question, and he states that he found the amount of carbonic acid gas at some stations reached 10·3 parts per 10,000, while in the tunnels it rose to 11·9, that is, from four to seven parts beyond the permissible limit. Dr. Blyth points out that owing to structural arrangements ventilation depends entirely on the passage of the trains, and the tunnel air is diluted, but never thoroughly swept out. We cannot help thinking that the crux of the matter has not been grasped by any of these critics. That there is a fine upcast draught in the approaches must be evident to all who have gone down the lifts or staircases just before the advent of a train. In our humble opinion, what is wanted is a downcast to supply fresh air, to be artificially propelled if need be. Further, a proper direction must be given to the air propelled before the trains. Under the present arrangement the air driven into one half of a station is simply transferred to the other side by a fatuous system of open doorways. A more ingeniously absurd plan of thwarting natural ventilation could hardly have been devised.

#### The Hygiene of Restaurant Kitchens.

THE sanitation of public kitchens, meaning thereby the cooking quarters attached to hotels and restaurants, has been recently going the round of the newspapers. Some years ago the matter was investigated by a well-known medical officer of health, who laid some remarkable facts before the attention of customers of the useful institutions in question. But his voice was that of a man crying in the wilderness, for nothing has been done to amend the evil, although considerable advances have been made towards improving the condition of bakeries, which about the same time received his unremitting attention. To begin with, one fatal flaw is extremely common both in bakehouses and kitchens, namely, they are underground. No satisfactory cleanliness and wholesomeness can be hoped for in either case if the operations are conducted on premises below the general level of the surrounding surface. The next great requirement is registration and licensing, accompanied by systematic inspection and control by

a central authority, such as the district county council. Nothing short of central administration will ever secure sound sanitation in bakehouses and kitchens, for here, as in other branches of public sanitary administration, efficiency can only be obtained by a system that is prompt, thorough, independent, and impartial. With a fair amount of experience in the matter of hotel and restaurant kitchens we have little hesitation in saying that an authoritative inspection, conducted upon a fairly wide scale, would secure a plentiful crop of "revelations" of a loathsome and revolting character.

### The German Emperor and the Study of Cancer.

THE Emperor William, with his usual directness of aim, has taken steps to place the study of cancer under the most favourable conditions possible to modern scientific research. It has been announced that he has requested Professor Ehrlich to devote his whole time and energies to the study of the disease in question. At the same time the Professor will have the advantage of a magnificently appointed chemical and bacteriological institute, while an Austrian specialist has been appointed as his assistant and coadjutor. This step is in accordance with modern views of the right and proper environment required for advanced scientific researches. With some reserve it may be said broadly that no returns can be looked for from a great deal of such work unless a corresponding amount of money is expended. That does not mean that scientific investigators are a whit less single-minded and enthusiastic in their labours, but simply that methods of exact investigation nowadays demand the use of costly methods and infinitely varied and elaborate apparatus. The secret of the causation of cancer is so elusive that if mankind can ever hope to wrest it from the hand of Nature, it is only by means of a concentrated, sustained, and well-equipped attack. The pathetic family experience of the Kaiser's family has no doubt impressed them deeply with the desirability of some practical step of the kind. Here in the United Kingdom the matter has been mooted in some of the public newspapers, but nothing has been done by way of establishing a systematic school of special study of cancer. State-supported science does not flourish on British soil.

### An Important Vaccination Appeal.

THE vaccination officer at Leicester recently instituted proceedings against the father of an unvaccinated infant for non-compliance with the law, and the case excited considerable interest because it was regarded as a test case, some 60,000 defaulters awaiting the decision in Leicester alone. The defence was based on the assumption that the vaccination officer had no legal right to initiate proceedings in opposition to the formally expressed views of the guardians. The case was argued at great length, and resulted in the defendant being fined. An appeal has been lodged against this decision, the outcome of which

will be eagerly awaited on every hand. The only serious contingency is the possibility of the decision being reversed on some technical point, leaving the question at issue undecided, but in view of the very careful consideration given to the arguments by the magistrates we hope such may not be the case.

### A Royal Example.

It is announced that, by order of the King, all the servants at Marlborough House have been vaccinated by his Majesty's physician, Sir Francis Laking.

IN answer to a correspondent, the Minister of War states formally that there is no present intention of removing the Army Medical School from Netley to London, and that no change will take place "unless by the strongest advice of medical authorities." This assurance does not take us very far since, as the subject is actually under consideration, it only affirms the fact that no alteration of the kind will take place unless it be decided otherwise.

THE Opening Meeting of the Dublin University Biological Association will be held on Thursday, November 14th, at 8.15 p.m. An Inaugural Address will be delivered by the President, Dr. R. Travers-Smith, on "An Apology for Bacteria." Among the speakers will be Professor J. M. Purser, D.Sc., the President of the College of Physicians, and H. H. Dixon, D.Sc.

THE Inaugural Address at the opening of the Medical Session at Jervis Street Hospital will be delivered to-day, at 4.30 p.m., by Dr. Austin Meldon, D.L.

THE Autumn Session of the General Medical Council will commence on Tuesday, November 26th.

### PERSONAL.

DR. DONALD MACALISTER resigns the Professorship of Medicine at the University of Cambridge, which will become vacant at Christmas.

DR. JOHN MACINTYRE, of Glasgow, has been re-elected President of the British Laryngological Association, and will deliver the Opening Address on Friday next.

DR. J. MITCHELL WILSON has been elected County Medical Officer for the East Riding of Yorkshire, having previously occupied the post of Health Officer for Doncaster.

SURGEON-GENERAL A. F. PRESTON, M.B., Director General, Army Medical Service (temporarily), has been appointed an Honorary Physician to the King, vice Surgeon-Major-General W. A. Thomson, M.B., deceased.

At the conferring of Degrees at the Royal University of Ireland last week, Lord Dufferin announced the award of a gold medal with distinction to Mr. Wm. J. Dargan, M.B., B.Ch., B.A.O., of the Catholic University School.

MR. THOMAS EVANS, M.B., M.S., has been presented with a handsome silver spirit tantalus by the officers

and nursing staff of the Holborn Infirmary, on his appointment as Medical Superintendent of the City of London Workhouse.

PROFESSOR HUGH L. CALLENDER, F.R.S., has been appointed to the Professorship of Physics in the Royal College of Science, rendered vacant by the resignation of Professor Rucker, who has become Principal of the University of London.

DR. W. E. SMITH has resigned his appointment of Medical Officer to the School Board of London, in consequence of the refusal of the Board to allow him to hold certain other paid appointments which prevented him devoting his whole time to the duties of his office

## Scotland.

[FROM OUR OWN CORRESPONDENT.]

DECREASE OF STUDENTS AT EDINBURGH UNIVERSITY.—In an interim report dealing with this matter the Finance Committee of the General Council point out that there was a steady diminution from 3,500 in 1889-90 to 2,800 in 1895-96, since which date the numbers have fluctuated near the latter figure. It cannot be said that the report sheds much fresh light on the causes which have led to this state of affairs, so far, at least, as the medical faculty is concerned, since the reasons have been fairly obvious to anyone considering the matter. The Committee state that for a generation prior to 1889 Edinburgh held a foremost place among the medical schools of the world; it attracted not only an abnormal number of students, but also an unusual number of men destined to teach elsewhere. The school has, in short, for years been shedding many of its best medical teachers over the globe. The competition thus brought about affects Edinburgh in several ways. The mere increase of teaching centres would reduce the number of students coming from a distance, and these must specially be taken into account; the great strides of medical education in the midlands of England, in Wales, in America and in Germany. Another change is the growing importance of practical, as compared with systematic instruction. Newer institutions, often with younger teachers, are more ready to adapt themselves in this respect, while the Scottish schools of medicine are clinging and striving to keep to both methods of instruction. This entails increased work on the student, and a longer drain on the purses of their parents. In addition to the above causes, which specially affect the medical faculty, the improved social status of commerce as a calling, the establishment of journalism as a profession, the advance in the standard of instruction of secondary schools, the improved status of teaching as a profession, the reduction of the stipends of the Established clergy, nay, even the substitution for patronage of a preaching competition for election to charges, with "its deterrent effect upon sensitive natures," have contributed to diminish the number of students as a whole. Financially, the decrease is of serious importance. Prior to the Act of 1889 the Professor drew the whole class fees. The professorial incomes regulated by that Act was thus based on incomes which were at their height when the Act came into operation, and which were, as events have proved, temporarily inflated. With a falling revenue the same salaries have still to be paid, and the competition of other schools has necessitated additional expenditure on teaching laboratories, &c. For remedies for this state of matters the Committee look to improvement in the teaching, increased flexibility and adaptability in the staff and arrangements, and a greater vigilance on the part of the authorities to prevent grievances; secondly, to the development of some means (postgraduate scholarships or the like) of inducing the best men to stay in Edinburgh; and then, relief to the overcrowded curriculum by the transference of preliminary subjects, botany, zoology, physics, and chemistry, to the secondary schools.

GENERAL MEDICAL COUNCIL ELECTION.—It is announced that Dr. Norman Walker has consented to stand for election as direct representative for Scotland. Though he cannot now claim to stand in the ranks of the great body of general practitioners, Dr. Walker was for a number of years in general practice, and has always continued to interest himself in the needs of those who, after all, form the backbone of the profession.

PLAGUE IN GLASGOW.—Glasgow has been visited by plague for the second time within over a year. Rumours to this effect have been current for some days but were not officially confirmed until November 1st. All the cases have occurred among the employés of one of the largest hotels in the city, and on Friday the directors of the Caledonian Railway Company, to whom the hotel belongs, took measures to close the establishment. It appears that the outbreak was first brought under notice of the sanitary authorities early last week, and on Wednesday two patients, and on Thursday another, were removed to the Fever Hospital. One of them has died, and the pathological and bacteriological examinations prove conclusively that the disease is plague. Since then two more suspected cases have been found. The Medical Officer of Health states that although the source of the outbreak has not been fully traced, it has been definitely ascertained that it has no connection with the cases recently reported among the crew of the Anchor Liner *Bavaria*, which came into port about a fortnight ago. These cases were treated in the Govan Hospital. Glasgow has, and deservedly has, the reputation of being a model municipality, and its public health department in no way lags behind its fellows. The success with which the previous outbreak was met leads us to hope that this one may be equally satisfactorily dealt with; active steps are being taken to exterminate the rats with which that part of the city is infested. The municipality has been engaged during the past year in a vigorous crusade against these vermin, and within the past two or three months some five hundred have been killed and examined. So far the outbreak has remained limited to the Central Hotel—an extremely restricted area as compared with the previous one—and this has been converted into a reception house for the servants, numbering about three hundred, who are employed in it. They are thus under complete medical supervision, and in addition they have been inoculated with anti-plague serum. A clean bill of health can no longer be given to ships leaving Glasgow, but as yet there has not been time for the outbreak to disorganise the shipping trade to any extent.

## Correspondence.

[We do not hold ourselves responsible for the opinions of our correspondents.]

### THE CURE OF CONSUMPTION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR

SIR,—The correspondence under the above heading begun in August last in *The Times*, still drags its slow length along, and continues to be at once equally amusing, instructive, and deplorable. Colonel Le Poer Trench, like a gallant soldier, still sticks to his guns and reiterates his belief that Alabone's great discovery has been deliberately "suppressed" by the profession, so that thousands of cases "pronounced incurable by ordinary treatment" have been wilfully allowed to perish miserably whilst within reach of the salvation afforded by Alabone's miraculous method. For purely sordid or selfish reasons or in obedience to trades union commands, the whole profession have—it is thus alleged—conspired to make a martyr of a great discoverer, and have murderously withheld from suffering humanity the benefit of his treatment. The conspiracy has been joined in by the large number of pure scientists who do not practice medicine but devote themselves entirely to research, and has been participated in by the same class as well as the entire profession of medicine throughout the civilised world, the whole of whom have hitherto shamefully but consistently ignored and despised Alabone and all his works. Col. Trench is quite intelligent



enough to understand that this is the extended logical statement of his arguments, and he reiterates his charge notwithstanding. If Col. Le Poer Trench stood alone or in a very small minority of the public capable of seriously holding and publicly asserting such a monstrous belief the fact would not be remarkable; but it certainly is a remarkable fact, and one well worthy full discussion that a large proportion of the public in every rank of life have equally little respect for the profession; have as little confidence in medical science, and are as ready to reject its authoritative opinion in favour of that of any pretender loud voiced and persistent enough in his claims to attention.

Colonel Trench's letter is next followed by one from Sir W. Broadbent, pithy, smart, and ending with an *apropos* Latin quotation, but quite insufficient to be in any way adequately explanatory to the average reader of *The Times* who needs enlightenment and guidance not to be found in a few epigrammatical statements. Having entered into the controversy, it seems a pity Sir William has not written at sufficient length to make the matter fully and clearly comprehensible, at least to the intelligent lay reader.

Dr. Pollock next writes and adds the important information that he has retired from practice. If he had made this known in his first letter he would have avoided giving a point to his adversaries, who were able to reply with a vulgar *tu quoque* to his charge of obtaining a gratuitous advertisement from the correspondence. Dr. Pollock's independent position being known he might, with great advantage to the public and the profession, have discussed the whole question at sufficient length. Dr. Pollock is of course followed by the martyr Alabone. He scorns to reply to the libellous imputations of his enemies. It is enough for him that he has had a quarter of a century's experience of the wonder-working powers of the lachnanthes treatment, and only prays for the day when generally adopted and used in the hospitals it may increase the tale of cases cured to a figure beyond the present deplorable average. One cannot foretell what may happen at the hospitals, but it is satisfactory to know at any rate that patients in great numbers are deserting their old-fashioned, stupid, and prejudiced regular medical attendants, and are rushing to the consulting rooms of Alabone and his disciples, there to be cured by the simple method now so fully and scientifically explained. If no other good than this had come out of the correspondence in *The Times*, if it had not at the same time exposed the true character of the medical profession and enabled the world to estimate them at their proper value an immense service to mankind would at least have been performed. Not often does a correspondence in *The Times* so speedily achieve such a glorious result.

I am, Sir, yours truly,

October 30th, 1901.

UBIQUE.

#### THE ELECTION OF DIRECT REPRESENTATIVES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I think all will agree with Mr. Victor Horsley that we must look to the British Medical Association for reform of the General Council of Medical Education and Registration—indeed, for the many changes so urgently needed in the affairs of the profession. This being his view it is singular that he should suggest as the best means of bringing about reform—the return of Dr. Woodcock as a “Direct Representative” on the General Medical Council. Dr. Woodcock has been for years on the Council of the Association—he was sent there by the Lancashire and Cheshire Branch entirely on account of his avowed opposition to the registration of midwives. He has kicked away the ladder he climbed up to his present exalted position, and declares himself a registrationist. The electors have no choice but to vote for Dr. Glover, who is a consistent registrationist, and Dr. Woodcock on the one hand, and Mr. George Brown and Mr. Jackson on the other, both of whom emphatically decline to tamper with the “Unity of Medicine.” The election will be fought as before, on the vexed midwives' question, and very

properly so. Legalise the aspirants to a position without qualification, and no alteration of the Medical Acts will ever retrieve the damage. These women will be duly qualified medical practitioners as far as obstetrics is concerned, and will demand and have a right to expect our services in consultation with them.

The feeling is very strong here upon this question, and this probably is the reason of the very delicate and modest manner in which Dr. Woodcock referred to the “Guild scheme” at his Liverpool and Manchester meeting, a scheme he before characterised as quite impracticable.

I think it reasonable to expect a candidate who has had so many years' experience and official responsibility to give a liberal account of his work, successes and failures, when addressing the electorate.—I am, Sir, yours truly,

JAS. BRASSEY BRIMLEY.

Old Trafford, Manchester, Nov. 2, 1901.

P.S.—Mr. Horsley asks us to refuse Dr. Woodcock and Mr. Jackson. This, of course, carries with it a further act—we must turn out the sitting members, Dr. Glover and Mr. George Brown. I imagine Mr. Horsley's *ipse dixit* will be resented by many electors. District representation is doubtless the ideal—but the first condition is a suitable candidate, no matter where he resides. We want men, like Mr. Horsley himself, independent of the petty “flatteries or threats of humanity,” fearless of opposition and with courage to lead minorities.

#### THE MISUSE OF THE BRONCHITIS KETTLE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Now that the winter is on us, with its moist, foggy atmosphere, medical men will be called on to treat great numbers of cases of bronchitis in young children and elderly people. May I venture to protest against the routine use of the bronchitis kettle. It is not denied that in certain dry, hard N.E. winds the bronchitis kettle may soften the air in a room, and may ease the breathing of a sufferer, but I refer to its routine and continual use in cases of bronchitis. I have entered a bedroom of a lady at 11 p.m. on a foggy November night, and found a bronchitis kettle pouring out its steam, whilst the gas fireplace had no effective connection with the chimney; the patient, aged 74, was sitting up in bed gasping for breath and life. I removed the kettle, effected a connection between the gas fire and the chimney; in a few hours the patient was lying back in bed in ease and comfort. I had removed the oppressive moisture of the room, also I had retained the gas fire to promote dryness of the air of the room, whilst the irritating fumes of the gas fire had been conducted into the chimney.

This is not by any means a solitary instance. The bronchitis kettle seems to be a fashion or fad; its occasional value is not denied, but its routine use is often a cruel punishment and injury to the patient.

I could always breathe gloriously on an Australian plain, with a difference of 16° F. between the wet and dry bulbs; but breathing was often oppressed in Bengal in the south-west monsoon, with the atmosphere laden with moisture.

I would refer your readers to a grand discourse by the late Sir B. W. Richardson on this subject in your issue of January 25th, 1888 (“Clinical Readings and Practices—Hydrops Bronchialis”); those who may read that essay will receive much light and knowledge.

I am, Sir, yours truly,

WILLIAM H. PEARSE, M.D.

Plymouth, October 23rd, 1901.

#### A Midwife Committed for Manslaughter.

A MIDWIFE at Mile End has been committed for trial on a charge of manslaughter on the coroner's warrant. Judging from the evidence, she must be a descendant of Mrs. Gamp, only worse, but we doubt very much whether any useful purpose will be served by her committal, the throwing out of the bill by the grand jury being almost a foregone conclusion.

## NEW BOOKS AND NEW EDITIONS.

The following have been received for review since the publication of our last monthly list:—

London: BAILLIÈRE, TYNDALL AND COX.

The Pocket Gray; or, Anatomists' Vade Mecum. Fifth Edition, Revised and Edited by O. Herbert Pagge, M.B.Lond., F.R.C.S. Price 3s. 6d. net.

Lessons on Massage. By Mrs. Margaret D. Palmer, Masseuse and Manager of the Massage Department at the London Hospital. Price 3s. 6d. net.

London: J. AND A. CHURCHILL.

Outlines of Gynaecological Pathology and Morbid Anatomy. By C. Hubert Roberts, M.D., F.R.C.S. 150 illustrations. Pp. 332. Price 21s.

A Short Practice of Midwifery. By Henry Jellett, M.D., F.R.C.P.I. Third Edition. Price 8s. 6d.

An Introduction to the Bacteriological Examination of Water. By W. H. Horrocks, M.D., B.Sc. Pp. 300. Price 10s. 6d.

A Manual of Practical Anatomy. By the late Professor Alfred W. Hughes, M.B., M.C., F.R.C.S. Ed. Edited and completed by Arthur Keith, M.D., F.R.C.S. Part I.: Upper and Lower Extremities. Pp. 274. Price 10s. 6d.

Pharmacopœia of the Hospital for Diseases of the Throat (Golden Square). Edited by H. Lambert Laok, M.D., and C. A. Parker, F.R.C.S. Ed. Sixth Edition. Pp. 75. Price 2s. 6d.

London: HENRY KIMPTON.

The Principles and Practice of Medicine. By Wm. Osler, M.D., F.R.S., Prof. of Medicine in the Johns Hopkins University, Baltimore. Fourth Edition. Pp. 1,182. Price 18s. net.

Manchester: HEYWOOD AND SON.

Blackpool as a Health Resort! By Thomas Carr, M.D., Durh., M.R.C.S.

London: J. S. KING AND SON.

Public Health and Housing. By John F. J. Sykes, M.D. (Milroy Lecturer). Pp. 216.

London: H. K. LEWIS.

Transactions of the Dermatological Society of Great Britain and Ireland. Edited by C. H. Thompson, M.D., and E. G. Little, M.D. 1900-1901. Pp. 59. Price 5s.

Edinburgh: E. AND S. LIVINGSTONE.

Handbook of the Public Health. By John Orr, M.D., F.R.C.P. Ed. Pp. 236. Price 4s. net.

Newcastle-on-Tyne: LONGHURST.

Manipulation or Massage. By John A. Peters.

London: LONGMANS, GREEN AND CO.

Diseases and Injuries of the Teeth. By Morton Smale, M.R.C.S., L.D.S., and J. F. Collyer, L.R.C.P., M.R.C.S., L.D.S. Second Edition. Pp. 685. Price 21s.

Elementary Practical Hygiene (Section I). By Wm. S. Furneaux. Pp. 239. Price 2s 6d.

London: MACMILLAN AND CO., LIMITED.

Practical Histology. By J. N. Langlev, M.A., Sc.D., F.R.S. Pp. 340. Price 6s.

New York and London: PUTNAM'S SONS.

The Care of the Consumptive. By C. F. Gardiner, M.D. Pp. 182.

Edinburgh and London: YOUNG J. PENTLAND.

Text-book of Pharmacology and Therapeutics. Edited by W. Hale White, M.D., F.R.C.P. Pp. 1,040.

London: HENRY BENSHEW.

Dictionary of Treatment. By W. Whitla, M.A., M.D. Fourth Edition. Pp. 1,053. Price 16s.

London: SWAN, SONNENSCHN EIN AND CO.

A Treatise on Plague. By Major G. S. Thomson, M.B., M.Ch., and John Thomson, M.R.C.S., L.R.C.P.I. Pp. 299.

Society "Schwann's Microscopic Researches into the Accordance in the Structure and Growth of Animals and Plants," and of a Memoir by Professor Bischoff, and had contributed various clinical lectures to the pages of this and other medical journals.

## Laboratory Notes.

### DAD'S QUININE PILLS.

WE have received from Messrs. Battle, of St. Louis and Paris, samples of Dad's Quinine Pills. The quinine contained therein—each pill being equal to two grains of the salt—is claimed to be produced by a new process, and to be more active than the ordinary drug. In addition to this, it appears to be comparatively free from the unpleasant secondary effects which in some subjects follow the ingestion of quinine. These pills are sugar-coated and irreproachably made, and we have ascertained that they contain pure quinine, responding to the standard tests in regard to solubility in the various media. The form is a convenient one in which to administer the drug, and accuracy of dosage is ensured, moreover, the price at which they are sold makes them also one of the cheapest.

### PHENALGIN CAPSULES (PINK TOP).

WE have received from the Etna Chemical Company, U.S.A., via Mr. E. J. Reid, of Basinghall Avenue, London, E.C., a sample phial of their specially-prepared Pink Top Capsules of Phenalgin. Each capsule contains five grains of this well-known analgesic and anti-neuralgic remedy, and they appear to constitute a convenient and exact way in which to prescribe this substance, especially as the cost is stated not to exceed that of the drug in ordinary form. We may remind our readers that phenalgin is a coal-tar derivative containing ammonia, which is liberated in the stomach in a nascent state, and exerts its usual tonic and stimulating action, thus effectually combating the tendency to depression which characterises the analgesic effects of this group of medicinal compounds. They readily dissolve when left in contact with moist heat. They are uniformly sold in one-ounce bottles.

### CREOSOTED EMULSION OF COD-LIVER OIL WITH HYPOPHOSPHITES.

MESSRS. PARKE, DAVIS AND Co. prepare an Emulsion of Cod-Liver Oil with Creosote and the Hypophosphites of Calcium and Sodium, a sample whereof has been submitted to us. The emulsion is remarkably complete and stable, and the taste of the oil is completely masked by the creosote, which, moreover, possesses valuable therapeutical properties of its own in the very cases in which the oil is likely to be prescribed. The presence of the hypophosphites confers a tonic and reconstituent medication also of value in pulmonary disease, debility, &c. Taken with food, the emulsion does not repeat, and it appears to undergo prompt assimilation, judging from the absence of traces of the oil in the stools.

## Obituary.

### MR. HY. SPENCER SMITH, F.R.C.S.

THIS gentleman, whose death we have now to record at the ripe age of 89, at one time occupied a prominent position among the surgeons of his day, he having retired from practice about fifteen years since. He was admitted a member of the Royal College of Surgeons, England, in 1837, of which he was elected an Honorary Fellow in 1843, and occupied for some time a seat on the Court of Examiners and of Council. Mr. Spencer Smith was for many years on the active staff of St. Mary's Hospital, and was subsequently elected consulting surgeon to the hospital. He was also a Fellow and a Vice-President of the Royal Medical and Chirurgical Society. His contributions to medical and scientific literature were numerous and highly appreciated; among others he translated for the New Sydenham

## Medical News.

### Medical Sickness and Accident Society.

THE usual monthly meeting of the Executive Committee of the Medical Sickness, Annuity, and Life Assurance Society was held at 429, Strand, London, W.C., on the 25th ult. There were present Dr. de Havilland Hall (in the chair), Dr. J. B. Ball, Dr. Frederick S. Palmer, Dr. M. Greenwood, Dr. St. Clair B. Shadwell, Dr. W. Knowsley Sibley, Mr. J. Brindley James, Dr. J. W. Hunt, and Dr. Alfred S. Gubb. The favourable sickness experience of the early part of the year has been well maintained. The claims have been under the expectation both in number and in average duration, and, so far, the year's working shows a considerable margin in favour of the Society. The number of new entrants is also rather greater than in 1900, but the Committee, feeling sure that the membership of the Society would be greatly

increased if the benefits it offers were more fully known, appeal to the members to bring the business under the notice of their medical friends. In this way they can greatly aid the management in extending the useful work of the Society, and in keeping down the expenditure rate to the present low level, viz., less than 5 per cent. upon the premium income. Prospectuses and all particulars on application to Mr. F. Addiscott, Sec., Medical, Sickness and Accident Society, 33, Chancery Lane, London, W.C.

#### Death Under Ether.

A DEATH under ether occurred last week at the Great Northern Central Hospital, the victim being a young man, æt. 17, who was undergoing an operation for strangulated hernia. He succumbed when the operation was approaching completion. The coroner commented on the fact that death from ether was of exceedingly rare occurrence, and the usual verdict was returned.

#### Death from Half a Grain of Morphia.

An inquest was held a few days ago at Worthing on the body of John Franks, a retired surgeon, who had been in the habit of inhaling chloroform for the relief of pain. Having run out of chloroform he injected half a grain of morphia which proved fatal in spite of the efforts of Dr. Hinds, who had been called in when the symptoms of poisoning declared themselves. Dr. Hinds attributed death to the action of what he described as a dose of the alkaloid, "well within the margin of safety," on a constitution enfeebled by the habitual use of chloroform. We may point out, however, that half a grain of morphia is by no means a safe dose, death having on numerous occasions followed the ingestion of this quantity. A verdict of death by misadventure was returned.

#### Lady Medical Candidates.

THE managing body of the Lincoln County Asylum have decided to adhere to the practice of allowing qualified women to enter as candidates for posts on the junior staff of that institution.

#### Acquittal of a False Doctor.

ABSOLOM WILLIAM HEAD, described as a medical assistant, was tried on a charge of manslaughter last week at the Central Criminal Court, he having falsely represented himself to be a medical practitioner to a patient who subsequently died from undiagnosed abscess of the liver. The jury acquitted him, adding a rider to the effect that no effort should be spared to make it impossible for unqualified persons to jeopardise the health of the public by indiscriminate treatment. The judge pointed out that the accused had laid himself open to a penalty for acting as a medical man; but, as Mr. Head will probably select some other sphere for his labours in future, the risk of prosecution is not very great.

#### Death in a Workhouse.

A ONE-TIME medical practitioner of Bridgend, Mr. George Joseph Llewellyn, has wound up a downward career by dying at the workhouse, whither he had been removed from a model lodging-house on being taken ill last week.

#### Dublin Sanitary Association.

At a meeting of the council of this Association held on the 29th ult., the following resolution was adopted:—"The attention of the council having been drawn to the fact that it appears from the weekly returns of the Registrar-General that in several instances each week the cause of death has been uncertified, there having been no medical attendant during the last illness, the great majority of such cases having been those of children under one year of age, they are of opinion that such a state of things calls for serious attention with a view to insuring that no death should be registered without proper certificate, and that where no medical certificate of the cause of death can be obtained the cause should be ascertained by an inquest." Copies of this resolution were ordered to be forwarded to the Local Government Board, Public Health Committee, and to the coroners for the City and County of Dublin. We have on so many occasions called attention to this serious condition of affairs that it is satisfactory to see that the Sanitary Association have also undertaken the task of directing public attention to it.

#### Royal College of Surgeons, England.

THE annual meeting of fellows and members will be held at the college in Lincoln's Inn Fields on Thursday, the 21st inst., at 3 o'clock p.m., when a report from the council will be laid before the meeting. Fellows and members can obtain copies of the report on application to the secretary, and can, if they so desire, register their names as wishing to receive the report annually. Motions to be brought forward at the meeting must be signed by the mover, or by the mover and other fellows and members, and must be received by the secretary not later than November 11th.

#### The British Laryngological Association.

DR. JOHN MACINTYRE, of Glasgow, has been re-elected President for a second term of the British Laryngological, Rhinological and Otological Association. He will deliver the Presidential address at the next meeting of the Association, which takes place at 11, Chandos Street, on Friday next, November 8th, at 5 p.m. The title of the address will be "The Application of Physical Science to the Surgery of the Nose and Throat." It will be illustrated by photographs and cases demonstrating in a remarkable manner his treatment with electrical discharges, which differ materially, both in character and application, from those in present use.

#### Surgical Instruments at the Naval and Military Exhibition.

MESSES. ARNOLD AND SONS, the well-known surgical instrument manufacturers, ask us to announce that they have received the highest award for excellence in workmanship at the Naval and Military Exhibition, Crystal Palace, and also the highest award at the Military Exhibition, Earl's Court.

### Pass Lists.

#### Conjoint Examinations in Ireland by the Royal College of Physicians and Royal College of Surgeons.

SECOND Professional and Third Professional Examination.—Candidates have passed these examinations as undernoted:—Second Professional—Part II.—Honours: Jas. Parker. All Subjects—Pass: R. G. Allen. Completed Examination: E. C. Byrne, M. A. Denuy, P. Maher, T. S. Reeves, J. W. Rutherford. Third Professional Examination.—All Subjects: W. J. Greeny, J. B. Logan, Miss M. E. M. Logan, J. J. Moore, M. J. Pierce (four years). Completed the Examination: C. H. Browne, H. M. Clarke, S. H. Curry, W. F. Delany, G. H. Enright, D. Jones (four years), A. T. Mulhall, J. Murphy, M. A. A. O'Brien, Geo. C. Robinson, J. P. Ryan, J. H. White.

#### Royal Colleges of Physicians and Surgeons of Edinburgh and the Faculty of Physicians and Surgeons of Glasgow.

THE quarterly examinations of the above board, held in Edinburgh, were concluded on 26th ult., with the following results:—

First Examination, Four Years' Course.—Of five candidates entered, the following four passed the examination: James Sydney Cooper, William Patrick Timmon, Joseph Edmund Mullan, and Joseph John Bell.

First Examination, Five Years' Course.—Of nineteen candidates entered, the following seven passed the examination: Terence Owens, Alexander Brown, Tom Newman Darling, Robert Percy Hosford, Wilfrid Metcalfe Chambers, Leo Patchett, and Victor Brown; and one passed in physics, two in elementary biology, and three in chemistry.

Second Examination, Four Years' Course.—Of ten candidates entered, the following five passed the examination: Norman Pigott Fairfax, Jesudason Joseph Anthony Pillay, John Gilmour, Charles Vaughan, and Edward Robert Harriott; and one passed in physiology, and one in materia medica.

Second Examination, Five Years' Course.—Of twenty-six candidates entered the following thirteen passed the examination: William Lang Hodge (with distinction), Alexander Blaxell Hugh Pearse, Ian Campbell, Donald Cameron (with distinction), George Morley Arundel Thomas, William Fleming, Denis Christopher Callaghan (with distinction), Harry Armstrong, John David Jones, Charles Richard Whittaker, James Joseph Egan, John Watson, and Rudolf Baranov; and three passed in anatomy and two in physiology.

## Notices to Correspondents, Short Letters, &c.

CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive signature or initial*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

### THE NOTORIOUS EAR-DRUM SPECIALIST—NICHOLSON.

It affords us much pleasure to place on record the fact that that arch-quack, "Dr." Nicholson, whose nefarious practices we exposed in these columns some time ago, and who has since adopted various aliases and concocted numerous frauds, the "Nicholson Aural Institute," the "Holbeck Institute," to wit, was last week sentenced at the old Bailey Sessions to eighteen months' hard labour. Will his ingenuity be equal to defrauding the labour-master in oakum-picking and the treadmill?

DR. BURNETT.—The publication ceased to exist some years ago.

DR. H. B. SMITH.—We do not consider that the enterprise, having regard to medical ethics, would be a legitimate one for a medical man to embark upon.

### THE BACTERIOLOGICAL TEST.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I have no wish to encroach on Mr. Berdoe's time, but I may say that the idea he entertains with regard to vivisection: being of "infinitesimal value" is not tenable in a scientific profession. On the other hand, if his feelings are so overcome that he discovers cruelty in the inoculation of mice I suggest that if a mouse were in the condition to offer an opinion of its own, it would probably prefer inoculation to being mauled to death by a cat, nature's form of vivisection.

I am, Sir, yours truly,  
CLEMENT H. SERS.

Queen's Road, S.E., Oct. 31st, 1901.

[\* \* This correspondence must now close.—Ed.]

## Meetings of the Societies.

### LONDON.

WEDNESDAY, NOV. 6TH.

OBSTETRICAL SOCIETY OF LONDON (20, Hanover Square, W.)—8 p.m. Specimens will be shown by the President, Mr. Bland-Sutton, Dr. Handley, Dr. Lewers, Mr. Doran, and Dr. Galabin. Paper: Mr. A. Doran and Dr. C. Lockyer: Sloughing Fibroid of the Left Uterine Cornu, Abnormal Relations.

THURSDAY, NOV. 7TH.

HARVEIAN SOCIETY OF LONDON (Stafford Rooms, Titchborne Street, Edgware Road, W.)—8.30 p.m. Mr. B. Brown: Twenty-five Years' Experience of Urinary Surgery in England. (Harveian Lecture.)

RONTGEN SOCIETY (28, Hanover Square, W.)—8.30 p.m. Mr. H. Jackson: Presidential Address.

CHILDHOOD SOCIETY (Library of the Sanitary Institute, Margaret Street, W.)—8 p.m. Discussion on the Subject of the Prize Essays.

NORTH-EAST LONDON CLINICAL SOCIETY (Tottenham Hospital).—4 p.m. Clinical cases will be shown by Dr. Tresilian, Dr. Willoughby, Dr. Whiting, and others.

FRIDAY, NOV. 8TH.

CLINICAL SOCIETY OF LONDON (20, Hanover Square, W.)—8.30 p.m. Papers: Mr. B. G. Moynihan: The Operative Treatment of Cancer of the Pyloric Portion of the Stomach. Mr. T. H. Morse: Case of Intracranial Section of the Second and Third Divisions of the Trigeminal Nerve for Severe Neuralgia. Mr. W. Hayward: A Case of Fragilitas Ossium.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM (11, Chandos Street, Cavendish Square, W.)—Dr. A. H. Thompson: Section of Orbital Tumour (?Endothelioma? Adeno-sarcoma). Mr. E. Nettleship: Chronic Serpiginous Ulcer of Cornea (Moore's Ulcer). Dr. W. E. Thomson: Three Cases of Keratitis in the New-born occurring after Instrumental Delivery, and resulting in each case in an almost identical Rare Form of Opacity. Dr. C. O. Hawthorne: On Intra-cranial Thrombosis as the cause of Double Optic Neuritis in Cases of Chlo-osis.

BRITISH LARYNGOLOGICAL, RHINOLOGICAL, AND OTOLOGICAL ASSOCIATION (11, Chandos Street, Cavendish Square, W.) 4 p.m. Annual General Meeting. Communications will be read and Cases shown by the President, Mr. L. Browne, Dr. Abercrombie, and Mr. Nourse. 5 p.m. Address: The President-Elect (Dr. J. Macintyre, Glasgow): The Application of Physical Science to the Surgery of Diseases of the Throat and Nose.

### DUBLIN.

WEDNESDAY, NOV. 6TH.

Opening Meeting of Session, Jervis Street Hospital, 4.30 p.m.  
Meeting of Council Pharmaceutical Society, 3 p.m.

THURSDAY, NOV. 7TH.

Council Meeting Royal College of Surgeons, 4.30 p.m.  
Examination for L.M. Royal College of Physicians.  
City Hospital for Diseases of the Skin, Annual Meeting, Mansion House, 4.30 p.m.

FRIDAY, NOV. 8TH.

Royal Academy of Medicine in Ireland, Section of Surgery, Royal College of Surgeons, 8.30 p.m.  
Stated Meeting Royal College of Physicians, 4.30 p.m.

MONDAY, NOV. 11TH.

Previous Medical Examination Dublin University commences.  
Examination for Licence in Dentistry, Royal College of Surgeons.  
Meeting of Pharmaceutical Society, 8.15 p.m.

## Appointments.

FALCONER, DONALD GORDON, M.B., M. S. Aberd., Certifying Surgeon under the Factory Acts for the Foyers District of Inverness-shire.

FARQUHARSON, A. C., M.B., M.S. Glasg., Medical Officer of Health for the Auckland Rural District.

GARDINER, PETER, M.D. C.M. Glasg., D.Ph. Lond., Honorary Medical Officer to the Camborne Dispensary.

GREY, T. CAMPBELL, F.R.C.S. Eng., L.R.C.P. Lond., Honorary Medical Officer to the Camborne Dispensary.

HAWTHORNE, C. O., M.D., M.R.C.P., Assistant Physician to the North West London Hospital.

LANCASHIRE GEORGE H., M.R.C.S. Eng., L.R.C.P., Assistant Physician to the Manchester and Salford Hospital for Skin Diseases.

MORRIS, T. H. P., M.R.C.S., L.E.C.P., Certifying Surgeon under the Factory Acts for the Hale worth District of Suffolk.

SLADEN, REGINALD J. LAMBERT, M.R.C.S., L.R.C.P., Senior Resident Surgeon to the Royal Sea Bathing Hospital, Margate.

SPENCE, JOHN W. L., L.R.C.P., L.R.C.S. Ed., Clinical Assistant to the Electrical Department of the Boys' Infirmary, Edinburgh.

THOMAS, J. TELFER, L.R.C.P. Lond., M.R.C.S., Honorary Medical Officer to the Cambo ne (Cornwall) Dispensary.

## Vacancies.

Bracebridge Asylum, near Lincoln.—Junior Assistant Medical Officer. Salary £125 per annum, with furnished apartments, board, attendance, &c. Applications to W. T. Page, jun., 5, Bank Street, Lincoln.

Brentford Union.—Assistant Medical Superintendent. Salary £100 per annum, with board, washing, &c. Forms of application to W. Stephens, Union Offices, Isleworth, W.

County Asylum, Lancaster. Assistant Medical Officer. Salary commencing at £150, with board, washing, &c. Applications to the Medical Superintendent.

County Asylum, Mickleover, Derby.—Senior Assistant Medical Officer. Salary commencing at £130, with board, washing, &c. Applications to the Medical Superintendent.

County Asylum, Prestwich.—Junior Assistant Medical Officer. Salary commencing at £150, with board, &c. Applications to the Medical Superintendent.

Dover Hospital. House Surgeon. Salary £100 a year, with board, lodging, and washing. Particulars to be obtained of E. Elwin, Esq., 2, Castle Street, Dover.

Essex County Asylum, Brentwood.—Fourth Assistant Medical Officer. Salary £150 per annum, with board, &c. Apply to the Medical Superintendent.

Glasgow University. Additional Examinerships in Medicine and Science, with special reference to Chemistry, Materia Medica, Zoology, Practice of Medicine and Surgery. Particulars as to dates, emolument, &c., on reference to our advertising columns.

Great Northern Central Hospital.—Surgeon on the Staff to attend to Out-Patients. Applications to L. H. Gleeton-Kerr, Secretary.

Lincoln County Hospital.—Senior House Surgeon. Salary £100 per annum, with board, lodging, and washing. Further information of W. B. Danby, Secretary.

## Births.

BELFRAGE.—On Oct. 30th, at 2, Montagu Place, London, W., the wife of S. Henning Belfrage M.D., of a son.

BIDWELL.—On Oct. 30th, at 59, Wimpole Street, Cavendish Square, London, W., the wife of Leonard A. Bidwell F.R.C.S., of a son.

ELKINS.—On Oct. 30th, at Leavesden, Herts, the wife of Frank Ashby Elkins, M.D., of a daughter (Mary).

WILLIAMS.—On Oct. 29th, at Rotorua, Harrow-on-the-Hill, the wife of Dr. A. H. Williams, of a son.

WOODHEAD.—On Oct. 27th, at Chisholme, Sale, Cheshire, the wife of Dr. H. Miall Woodhead, of a daughter.

## Marriages.

BRYANT—WATTS.—On Oct. 31st, at St. Paul's Church, Cambridge, Charles Hilary, M.D., F.R.C.S., third son of E. Ross Bryant, of Newcastle-on-Tyne, to Theodora Harvard Watts, fifth daughter of the late Thomas F. Watts, of Bracondale, Cambridge.

CARBERG FASTNEDGE.—On Oct. 31st, at St. George's Church, Stamford, Alfred Ernest Carberg, M.A., M.B. Cantab., youngest son of George N. Carberg, Esq., of Hornsey Lane, N., to Marbelle Ruth, youngest daughter of Richard B. Fastnedge, Esq.

DRURY RICHARDS.—On Oct. 31st, at St. James's Church, Piccadilly, London, Maurice O'Connor Drury, Surgeon-Major, retired, R.A.M.C., of Salsruck, Connemara, to Martha Louise, widow of the late Henry Brinley Richards, and daughter of the late Henry Wm. Nevill, of 16 Cranley Gardens, South Kensington.

POOLEY—DUDLEY.—On Oct. 30th, at St. Andrew's Church, Walcot, Bath, Charles Archibald Pooley, C.E. eldest son of Walter M. Pooley, of The Cedars, Bath, to Evelyn Margaret, eldest daughter of Brigade Surgeon-Lieut. Colonel W. Edmondson Dudley, R.A.M.C., of Bath and Templemore, Tipperary.

## Deaths.

ALLARD.—On Nov. 2nd, at Tewkesbury, Joseph H. Allard, M.R.C.S., L.R.C.P. Ed., aged 45 years.

BENNETT.—On Nov. 1st, at his residence, 47, Clarendon Gardens, Bayswater, W. A. Hughes Bennett, M.D. Ed, F.R.C.P. Lond., Consulting Physician to the Hospital for Epilepsy, late Physician to the Westminster Hospital.

SMITH.—On Oct. 29th, at 92, Oxford Terrace, London, W., Henry Spencer Smith, F.R.C.S., in his 59th year.

# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

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No. 20.

## Paris Clinical Lectures.

### THE SYMPTOMS AND COMPLICATIONS OF GASTRIC ULCER.

By Prof. ROBIN,

Professeur Agrégé of the Faculty of Medicine of Paris.

THE predominating symptoms of gastric ulcer are pain and vomiting, with constipation or diarrhoea. Simple gastric ulcer is an essentially painful affection, and the pains may in some cases become so severe as to urgently call for special treatment. The same, indeed, may be said of the other phenomena.

*Treatment of Pain.*—The painful manifestations are of two kinds. Either the pain is continuous or it comes on in acute attacks during digestion, under the influence of the secretion of hydrochloric acid. You will notice different forms, such as pyrosis, cramps or distressing sensations in the epigastrium. Now, of all the causes which excite the pain, the first in line is the ingestion of food. That is why I always insist on the necessity of absolute rest for the stomach. But, as I have pointed out on previous occasions, the diet cure cannot be continued indefinitely; and when the patient commences to eat he begins to suffer.

What, then, are the means at our disposal to give him relief? The first and the simplest is for the patient to take, five minutes before each meal, *four drops* of

Picrotoxine, } gr. j;  
Hydrochlorate of morphia }  
Sulphate of atropine, gr.  $\frac{1}{8}$ ;  
Ergotine, ℥ xx;  
Cherry laurel water, ℥ iij.

(A little spirit should be employed to dissolve the picrotoxine, which is not very soluble.)

The dose may be increased, but should not exceed twenty drops in any one day.

This mixture dulls the sensitiveness of the stomach towards the irritating contact of the milk or solid food. It will, however, sometimes happen that the pain is not relieved in spite of this prophylactic treatment; in such cases the best plan is to administer a powder which will neutralise the excess of acid which, as you know, is the immediate cause of the pain. The following is the formula which I employ:—

Lactose, grs. xx;  
Calcined magnesia, grs. xxx;  
Sub-nitrate of bismuth,  
Prepared chalk, a a grs. x;  
Codeine, gr.  $\frac{1}{10}$ ;  
Bicarbonate of soda, grains xx.

For one powder. To be taken by the patient in a little

water when in pain. If this does not prove successful I have recourse to preparations of belladonna or cocaine, as follows:—

Belladonna powder, aa ʒ gr.  
Ext. of belladonna,

For one pill, one to three in the twenty-four hours;  
or,

Cocaine, aa gr. j;  
Codeine, aa gr. j;  
Spirit of chloroform, ℥ ij;  
Lime water, ℥ viij.

To be taken in tablespoonful doses.

External applications are by no means without effect; the following liniment may be employed for example:—

Liniment of belladonna, ℥ iiss;  
Ext. opium, }  
" belladonna, } ʒss;  
" hyoscyamus, }  
Chloroform, ℥ ij.

This liniment applied to the pit of the stomach often gives excellent results where other treatments fail.

*Treatment of Vomiting.*—When patients suffer from obstinate vomiting the first thing to try is the picrotoxine mixture indicated above, as it will often afford relief; if not, apply a small blister to the epigastrium and powder with two grains of opium, or order inhalations of oxygen gas. One or other of these means usually succeeds. In the contrary event I know of only one means of arresting the vomiting, and that is a return to the rest cure.

*Treatment of Constipation.*—When there is constipation, a very frequent complication with those patients, we must, of course, give laxatives and enemata of warm water. The laxatives I employ are castor oil, calomel (calomel, grs. vi; jalapæ, grs. vi; calcined magnesia, grs. xv) in cachet form, or the following pills:—

Oape aloes, ʒss;  
Scammony }  
Jalap } xv grs.;  
Vegetable turpeth }  
Ext. of hyoscyamus } iij grs.;  
" belladonna }  
Castille soap, q.s.

Divide into fifty pills.

You will take care in writing the prescription to underline *vegetable turpeth* to avoid confusion with mineral turpeth which, as you know, is a preparation of mercury (sulphate). The vegetable turpeth is derived from a plant in Japan, and resembles jalap in its action.

One or two of these pills are to be taken at bed time.

*Treatment of Diarrhoea.*—This condition is rare, for out of fifty-two cases of my personal statistics I have observed but two in which it called for active treatment. I employ with constant success for this

complication a plant, to-day forgotten but unjustly so, for it possesses a real value not only in the diarrhoea of gastric ulcer but in a number of similar cases. I speak of the root of the wild strawberry (*Fuonyms*). It is a therapeutic agent long gone out of fashion, and might be ranked among the "simples," but nevertheless I strongly recommend it. The powdered root is given in doses of thirty grains, infused in a little water, and taken after meals. Not being toxic, the dose can be safely repeated several times a day.

*Treatment of Hæmorrhage.*—We now come to the treatment of a patient seized with hæmorrhage. Place him on his back, recommend absolute immobility, and apply ice over the stomach. The next step is to inject subcutaneously a solution of ergoline into one loin, and a gelatine solution into the other, according to this formula:—

Gelatine, pure, ʒvj;  
Chloride of sodium, ʒij;  
Distilled water, ʒxxxv.

Six drachms of this solution is to be injected under the skin. You will prescribe, also, the following mixture which should be taken in doses of a teaspoonful every hour:—

Ergotine, ʒj;  
Gallic acid, gr. x;  
Syrup of turpentine, ʒj;  
Dill water, ʒiv;

and between each hour a tablespoonful of:—

Chloride of calcium, ʒj;  
Extract of opium, gr. j;  
Syrup, ʒj;  
Water, ʒiv.

The chloride of calcium, as you know, has the property of increasing the coagulability of the blood. A copious enema will complete the treatment of this urgent stage.

On the other hand, should the hæmorrhage recur, however slightly, the patient must be placed on the absolute rest cure for a period of nine days at least and a fortnight at most.

The hæmorrhage is generally arrested by the above means, and this is an important point to note at the time when so much is spoken of surgical treatment as a substitute for the medical treatment of gastric ulcer. We will refer to this subject again by-and-by.

It happens sometimes that the patient, through loss of blood, is seized with syncope, and in such a case you must give injections of ether or normal saline solution. If fever be present you may be certain that some of the blood has passed into the intestine. This constitutes a grave complication, as intoxication may be the result. Should this be the case, give a purgative at once, and the best of them is certainly calomel according to the formula already given. When the hæmorrhage is exceedingly abundant, and the life of the patient is in imminent danger, you will not hesitate to perform *transfusion*, for it has given more than once unhopèd for results.

When all complications have disappeared, and the patient is slowly returning to health, prescribe perchloride of iron internally, not only as a hæmostatic agent, but in order to overcome the anæmia from which these patients so frequently suffer.

In concluding my remarks on this interesting subject of gastric ulcer and its treatment, I will give you in a few words my opinion as to the value of the radical cure advocated by our surgical colleagues. In the immense majority of cases the medical treatment succeeds, and if we compare the mortality of cases of gastric ulcer treated medically with that of the cases treated by surgical operations, we shall find that the former is markedly lower to the latter. The mortality of medical cases is 9 per cent., while

that of operated cases is 20 per cent. Consequently, the so-called radical cure should not be advised.

On the other hand there are complications which require surgical treatment, such as intestinal perforation, subphrenic abscess, cicatricial stenosis of the pylorus, perigastritis in patients obliged to work hard and who cannot obtain the special food necessitated by their condition, and finally in slight, but oft-repeated hæmorrhages which cannot be controlled by medical treatment.

## PYLORIC STENOSIS

### CAUSED BY HYDROCHLORIC ACID.

By PROF. NOTHNAGEL, M.D.,

Professor of Medicine in the University of Vienna.

I WISH to direct your attention to a peculiar case of poisoning with hydrochloric acid. According to the history of the patient he is 36 years of age, and a labourer. Three months ago he was brought into hospital after having swallowed two mouthfuls of pure hydrochloric acid while in an attack of mania.

During the subsequent fortnight he was fed per rectum. On the day following admission he vomited a large quantity of black clotted matter and remained unconscious for some time after. He suffered great pain during the next fortnight, and had to be nourished per rectum until he was able to swallow milk.

A bougie was passed into the œsophagus to prevent stenosis which never occurred. Later, however, pain in the stomach with vomiting after taking food set in, but subsequently vomiting occurred even when the stomach was empty. Rapid emaciation followed.

On being readmitted the thoracic organs were found to be healthy, and the abdomen was much contracted. In the left hypochondrium there was a distinct tumour of kidney shape, convex below and concave above. It was hard and firm, moving with every respiration. On lifting it forward and holding it in this position it gave the patient pain, but after a time it became softer, though no peristaltic action was to be observed.

The day after admission he vomited about a quart of food containing large quantities of sarcinæ, long bacilli, and yeast cells. There were also free hydrochloric and lactic acids present.

The stomach was carefully washed out, and tested shortly after, when hydrochloric and lactic acids were found, giving an acidity of 30° when titrated. The stomach was greatly dilated, and by its tonic contractions gave the appearance of a phantom tumour under prolonged observation. The large amount of lactic acid present combined with the emaciated cachectic appearance led us to suspect pyloric carcinoma. This was further confirmed by the hydrochloric accident, yet the œsophagus was apparently healthy.

He was afterwards transferred to the surgical wards, where Albert examined him and found the stomach enlarged, the walls thickened, and the lumen of the pylorus closed as if with a ligature. Gastro-anastomosis was performed and the patient made a perfect recovery.

Pyloric stricture after acid burn without affection of the œsophagus is a rare occurrence. Riegel relates one case of this kind in his "Hand-book of Surgery of the Stomach," where a labourer swallowed a quantity of sulphuric acid without doing any injury to the œsophagus, but set up narrowing of the pylorus with ectasia and reduction of free hydrochloric acid in the stomach. On opening the stomach in this case there was a large ulcerating cicatrix extending from the cardiac end along the great curvature to the pylorus.

He explained the absence of hydrochloric acid by the existence of gastritis toxica.

Beyland describes another case which developed about a month after swallowing a quantity of hydrochloric acid. There was shrinking of the pylorus, with hour-glass contraction of the stomach, and adhesions between stomach and parietal peritoneum, as seen when the operation was performed.

It is difficult to explain how the œsophagus and stomach escape injury while the pylorus is destroyed by the escharotic, unless it be due to a large amount of secretion and a thicker layer of epithelium in the higher portion of the alimentary tract, due probably to smoking, drinking, &c.; hence, when the escharotic is swallowed rapidly, enough of the epithelium is shed with a flow of secretion to neutralise the adhering acid.

Hadenfeldt's theory of the stomach escaping injury by reason of the acid being thrown across the smaller curvature, which is usually inflated with gas, is more fanciful than real. It appears from Riegel's case, quoted above, that the acid passes from the cardiac to the pyloric opening along the greater curvature of the stomach. The most probable explanation is that the fundus carries all fluids rapidly across the cavity towards the pylorus, where it is caught in its rapid flight, to linger and eat into the tissues, while the mucus and secretions of the stomach proper neutralise the acid in the same way that it did in the œsophagus.

Hammerschlag drew attention to the occurrence of lactic acid fermentation in his case, which he pointed out in a previous lecture was due to the reduction of the natural acids of the stomach, owing to insufficient mobility and stagnation of the contents, similar to that which occurs in carcinoma of the stomach. In his case there was a gastritis toxica, associated with altered secretion, which produced a similar effect.

In lethal cases all the glands are found full of leucocytes, with dilated vessels which produced atrophy of the mucous membrane and destruction of the secretory apparatus. Although atrophy is present in the gland, the walls of the stomach become hypertrophied by the muscular efforts.

## Presidential Address

ON THE

### ROLE OF PROTOZOA IN THE CAUSATION OF DISEASE. (a)

By ED. J. McWEENEY, M.A., M.D., D.P.H.,

Examiner in Pathology, Royal College of Surgeons, and Professor of Pathology in the Cath. Univ., Dublin.

AFTER some introductory remarks, in which he set forth the reasons which had induced him to select the parasitic protozoa as the subject of his address, the speaker briefly explained the characters of the Protozoal Organism. The single cell of which it is composed must exercise the several functions which among the Metozoa are carried out by the groups of differentiated cells termed organs. It must move, feed, and multiply. The manner in which the Protozoal cell discharges these functions is taken as the basis of classification. There are four great classes of Protozoa—the Rhizopoda, Sporozoa, Flagellata, and Infusoria. The Rhizopoda comprise the lowliest of living beings, amœbæ, formless lumps of protoplasm, moving by means of temporarily emitted pseudopodia, and differing from a human leucocyte only in their capacity for leading an independent existence. Amœbæ are normal inhabitants of the human intestine where they seem to have been first seen by Lambl in 1870. Lösch, in 1875, ascribed dysentery to their parasitism. Since then an extensive

literature has accumulated with reference to the causal relation in which amœbæ are supposed to stand to a certain form of dysentery termed "tropical" by Councilman and Lafleur in 1891. The speaker sketched the development of this doctrine, pointed out the sources of error that underlie not only some of the reputed findings of amœbæ in the fæces and in the pus of liver abscesses, but also invalidated some of the reputed positive results of animal experiment, and concluded this part of the subject by saying that, in view of the positive results recorded by Quinke and Roos, Kartulis, Kruse and Pasquale, and Zancarol, from the injection of bacterially sterile liver-pus into the rectum of cats, it was hardly possible to escape from the conclusion that the amœba coli is, by itself or in conjunction with Bacteria, responsible for the causation of "tropical" dysentery. He did not know whether any case of this disease had as yet been recorded in Ireland. He demonstrated a coloured screen picture of Amœba Coli. He then proceeded to describe the Sporozoa, animals which in their adult stage appear as amœbæ or else as more or less definitely-shaped protoplasmic masses, but which multiply by division into a greater or lesser number of encapsulated germs, which from their resemblance to the reproductive bodies of the fungi were often spoken of as spores. They had recently been shown to possess a highly remarkable sexual method of reproduction. Passing over the Gregarinidæ, as not found in the higher animals, he desired to lay special stress on the next order, the Coccididia. Species of coccidium, produced pseudo adenomata in the bile ducts of the rabbit and plaque-like thickenings of the intestinal wall. Severely affected animals die of cachexia and anæmia. The parasite had two developmental cycles, both passed within the same host-animal. The mature animal consists of a rounded coarsely granular mass of protoplasm (schizont) lying within an epithelial cell of the rabbit's intestine or bile duct. It splits up into numerous sickle-shaped segments (merozoites) which became amœboid and infect neighbouring cells. At a certain period schizogony came to an end, and two varieties of mature parasite become differentiated, one larger, more evenly granular, the macrogamete or female; the other smaller, more hyaline, the microgametocyte. Bi-flagellate bodies, the macrogametes or spermatozoa, are emitted from the latter, each carrying with it part of the nucleus. They penetrate into and fertilise the macrogamete, which increases greatly in size, assumes an oval shape and a doubly-contoured capsule, and, becoming detached from the epithelium, emerges with the fæces into the outer world, as a "sporont"—the coccidium of the older writers. Soon its contents become divided into four sporoblasts, each of which assumes a tough membranous investment, and being set free by the decomposition of the outer cyst-wall, is called a spore. Its destiny is to gain access to the alimentary canal of a fresh animal with the food, and there to liberate the two sickle germs (sporozoites) which had been meanwhile formed in its interior. He alluded to the reduction of the chromosomes and the Rest-körper or *corps de réliquat*. This interesting life history had been revealed through the labours of L. and R. Pfeiffer, Labbé, Léger, Schaudinn, Siedlecki, and Simond. What made it the more interesting was that it ran strictly parallel to the life-history of the malarial parasites, which had been recently so admirably cleared up through the work of Manson, Ross, Bignami, Grassi, and MacCallum. These parasites constitute the next order of Sporozoa, the hæmosporidia. The speaker then proceeded to trace out the developmental cycle of the parasites of human malaria, and to show that the phenomena were by no means isolated, but were strictly parallel to what had been shown to hold good for the Coccididia. The reproduction of the malarial parasite by sporulation in the circulation of the warm-blooded host was homologous with the schizogony of the coccidium in the rabbit's intestine. The sexual process of the malarial parasite differed from that of the coccidium in one feature only—the complication of a change of host, from the warm-

(a) Delivered at the opening meeting of the Section of Pathology, November 1st, 1901.

blooded vertebrate to the cold-blooded invertebrate animal. This change was, of course, effected by the agency of the mosquito. He insisted upon this homology as bringing the malarial parasite into line with other forms of parasitic protozoa. Turning next to the third class of Protozoa, the Flagellata, the speaker detailed the main facts known regarding this parasitism in the lower animals. The best known of these parasites was the *Herpetomonas*, or *Trypanosoma Lewisii*, often found in the blood of the common wild rat. Through the courtesy of Professor Cunningham he had that morning examined the blood of fifteen rats at the Zoological Gardens, and found the parasite in seven. He had brought down one of the animals, and now showed its blood, containing numerous actively motile fish-like parasites, each as long as three or four red discs, and provided with a long flagellum and an undulating membrane. He demonstrated a film stained by Romanowsky's method, showing the macro- and micro-nucleus stained red, and also the flagellum, an interesting fact for which he could not at the moment satisfactorily account. Although this parasite seemed harmless to the rat, a closely allied form, *Trypanosoma Brucei*, had been shown to be concerned in the causation of surra, a disease of transport animals in India, and of the famous nagana or tsetse fly disease in the warmer parts of Africa. He demonstrated a stained blood film from an experimental guinea-pig, which he owed to the kindness of the late Prof. Kanthack. As compared with those in the rat, some were blunter at the non-flagellate end. This did not hold good in all cases, and he could see no other difference. In conclusion, the speaker referred to parasitic protozoa of uncertain biological position. *Piroplasma bigeminum* was a minute pear-shaped or oval speck of protoplasm, often occurring two together in the red corpuscles of the ox affected with parasitic hæmoglobinuria or Texas fever. The parasite was discovered a few years ago by Theobald Smith and Kilborne in the United States. They found that its propagation from one ox to another was effected by ticks. A unique feature of this transference was that it was carried not by the female tick that had actually sucked up the infected blood, but by her progeny. Owing to the courtesy of Professor Mettam, Principal of the Royal Veterinary College for Ireland, he was in a position to show specimens of the parasite found for the first time in Ireland by that gentleman in the blood of cattle suffering from red-water. Of still more uncertain position was the supposed parasite of vaccinia discovered by Guarneri in the epithelium of the inoculated rabbit's cornea. Through the kindness of Dr. Gustave Mann, of Oxford, he demonstrated a preparation showing these bodies in almost every epithelial cell. The subject was one of some complexity, and opinions were much divided as to the interpretation of the "bodies" in question. He preferred to reserve this part of the subject for a further communication later on in the session. Lastly, the supposed protozoal etiology for carcinoma was a still more doubtful topic even than vaccinia. The tendency among recent Italian workers was to ascribe the disease to a blastomycete or yeast-form, which would, of course, be reckoned among the vegetable parasites. Sanfelice, of Naples, claimed to have obtained from fruit-juice an organism of this kind which had yielded positive results on inoculation. In England Plimmer had obtained from a rapidly-growing cancer a growth of an organism the biological question of which appeared doubtful. The results of the inoculation-experiments seemed to the speaker far from convincing. The several varieties of cell-inclusions that had been so industriously worked up and identified at first with coccidia, then with blastomycetes, seemed to him to be susceptible of other explanations. He now demonstrated some of these inclusions. In this connection it was interesting to note that ulcerated swellings exceedingly like tumours were developed on the roots of the cabbage and turnip as the result of the intra-cellular parasitism of *Plasmodiophora Brassicæ* (Wor), an amoeboid organism reckoned by some with the Myxomycetes, by others with the Protozoa. Cachexia and death of the host-plant was caused by this intra-

cellular parasite, which thus formed an interesting analogy to what was sought to be established in the case of human cancer. He demonstrated sections of the affected roots showing the cells filled with the parasitic protoplasm and subsequently with the small spores, into which it divided.

## THE STUDY OF CANCER. (a)

By AUSTIN MELDON, J.P., D.L.,

Ex-President, Royal College of Surgeons, Ireland; Senior Surgeon, Jervis Street Hospital; Consulting Surgeon to National Maternity Hospital; Ex-President, Irish Medical Association.

AFTER some introductory remarks, the speaker said:—When casting about for a fitting subject for my address my mind came to dwell upon the fact that the vast and rapid strides made in accumulating information on a disease which in recent years has apparently been on the rapid increase in Ireland might interest those whom I have the honour to address. I allude to that most terrible and fatal malady which afflicts the human race, "Cancer."

The first point which must be settled is whether cancer is a parasitic disease. Pathologists all over the world have agreed that there are appearances among cancer-cells which do not belong to the cells and are foreign to their structure and development. Some call them protozoa, others fungi, and some assert they are but degenerated cells. The latter contention may at once be dismissed, as these appearances are not found in the part of cancer undergoing degeneration but are abundant in the growing portion. Mr. Plimmer, the well-known pathologist, of St. Mary's Hospital, London, has recently, out of 1,276 cases, found parasites, which he believed to be the cause of the disease in 1,130. These he has been able to cultivate outside the body and when injected into other animals they produce tumours and death. In those in which they were not found the growths were either locally cured—sarcoma has been known to undergo spontaneous retrogression—or so degenerated that no stain could affect the cells. There has not been yet time enough however to prove beyond doubt whether these parasites are the cause or the result of the disease; but certain it is that they only exist in cancer and are not found in any other disease; that they exist only in the growing portion and not in the degenerate part, and the greater the number the more rapidly the cancer grows.

Adami and Roux have recently discovered micro-organisms so small that they pass through the fine porcelain, which till now was supposed to filter all germs, and are too small to be seen singly with the most powerful lenses, being only recognised when growing in colonies. These belong to other diseases, but may account for many hidden causes which, with new lenses and new stains will become clear and recognisable. As yet we must look on the parasitic origin of cancer as more than probable. Beyond this we cannot go at present.

There has been a large accumulation of facts which suggest that cancer is infectious, and, if it be due to parasites it must be communicable by contagion. On this point, during the past century, medical opinion was so uncertain that at one time cancerous patients were refused admission into some of the Continental hospitals, and special cancer hospitals were provided. Cancer undoubtedly haunts places, and has a great analogy to malaria, and, like the latter, shows a preference for marshy soil.

Mr. Power's view is that the germ of the disease, a *contagium vivum*, lives in some intermediate host belonging to the animal or vegetable kingdom, from which, or in which it somehow finds its way into a suitable place in the body of its human victim. Is it not possible that some kind of gnat or fly may prove to be an efficient host for the parasite, and, consequently, dangerous to man. Many flies, like mosquitoes, which are

(a) Abstract of Address delivered at the Opening of the Session 1901-2, in Jervis Street Hospital, Dublin.



recognised as conveying the malarial germs, cling to puddle and swamp, where they are hatched, and where they in turn deposit their eggs. Cancer is most common in damp and marshy places. It is, moreover, well known in other diseases acknowledged to be contagious that the micro-organism enters but leaves no trace whereby to track it, until it reaches the tissue suitable for its growth.

Much interest can be gleaned from the researches of Noel, which show a certain relation between arboreal and human cancer. Not only are malignant tumours more frequent in habitations on the borders of woods, but labourers and others who live among trees are very prone to them. Cancer bearing trees are exceedingly common in orchards. Insects, as Moran has experimentally shown, have a decided predilection for arboreal cancer, and carrying infection from one tree to another, may also infect fruit or other food. On these insects, protozoa and fungi have been found. Moran placed white mice over pans of turpentine and camphor so as to keep them free from insects, and they remained healthy, whereas white mice with whom bed-bugs, taken from cages of cancerous mice, were put, one and all developed the disease in a few months. Professor Löffler, of Greifswald, and many others have shown that in countries where malaria is prevalent cancer seldom ever appears. In Borneo, Dr. Pagel in ten years never met a case of cancer. It is quite true that the two diseases rarely exist in the same district. In Jamaica, Mauritius, the East Coast of Africa, and the Guinea Coast cancer is rare, but in Holland malaria and cancer are both common. In the Argentine Republic, Mr. Bath informs me, cancer is frequent, whereas malaria is almost unknown. In some localities it is more prevalent than in others.

In Ireland Armagh has the largest mortality from this disease, then follow Carlow, Dublin, and Athlone, whereas Kerry has the least. Dr. Seymour, medical officer of Bath, states that his district has 50 per cent. more cases of cancer than the adjoining neighbourhood.

Occupation seems to have some influence on the disease. From 1881 to 1890 47 per 1,000 of those registered were from cancer, the distribution being: Occupied males, 44; unoccupied males, 96; clergymen, 35; lawyers, 60; medical men, 43; commercial travellers, 63; stable men, 58; seamen, 60; porters, 48; farmers, 36; fishermen, 46; brewers, 70; hotel servants, 65; chimney sweeps, 156. The theory that excessive nervous strain and anxious work cause the disease could be contradicted by these figures, as medical men and clergymen are among those most free. It has been stated by at least one pathologist that cancer is peculiar to the human subject, and in days gone by many medical men believed this theory, but such is not the fact. Although the disease is not frequent among the lower animals, yet every veterinary pathologist knows that it is at times met with in almost every species of them. It is, however, a curious fact that the animal which seems most free from it is the pig. The study of this disease in the lower animals almost proves that it is not, at least, caused by irritation, as the parts most subject to this in animals are those almost exempt from the disease.

The question whether cancer is increasing in Ireland must be answered in the affirmative. In 1890 the total deaths from this disease were 2,145, and every year, from that time, there was a gradual increase, until in 1900 the deaths numbered 2,717. In 1889 Ireland had registered per 10,000 of population 4.5, whereas in 1898-1900 the figures were 6.1. In England, in the same period, the figures rose from 6.6 to 8.0, and in Scotland from 6.7 to 8.2. Some may say that this increase is but apparent, and is really due to the fact that our diagnosis is now more accurate, hence many deaths are now registered from this disease which were formerly doubtful, and, secondly, that cancer, being a disease of degeneracy, increases as age progresses, and there are greater numbers of survivors to the "cancer age," which is between thirty-five and seventy-five. This explanation cannot account for the gradual but startling increase in the mortality. It is, moreover, the only disease which is steadily on the increase all over the world.

We should have in our midst a Central Laboratory, pre-

sided over by a trustworthy chief, in whom the profession and the public should have the fullest confidence, and this institution should be in touch, not only with every hospital in Ireland, but also with all similar institutions abroad. All the great scientific centres, of which Austria, Italy, America, and Germany are the principal, where the Governments do so much to foster original research, should work together, and should frequently interchange their views and let every advance be at once known all over the world, so that all might follow up the latest discovery. Such a work cannot be done through private philanthropy. In this country the Government or Corporation should undertake to found and maintain a properly equipped institution replete with everything necessary for important research, and, if necessary, a rate should be levied, as it is at present, for school attendance, technical instruction, reading rooms, and other things essential to the common weal. When this is done rapid progress will be made, especially when we obtain more powerful lenses, new stains and more media, all of which are now so urgently required. The matter is so important, and comes home to so many, that I feel certain the ratepayers would not object to the small amount which would be necessary to carry out this proposal, and the State has already shown that it feels its responsibility in this direction.

Our beloved King said, a short time ago, when addressing the delegates of the Congress on Tuberculosis:—"God grant that before long you may be able to find a cure for cancer, or check its course, and I think that to him who shall make the discovery a statue should be erected in all the capitals of the world." I venture to predict that within the next few years Heaven will hear this earnest prayer, and cancer will be numbered with the curable diseases.

## SAFETY EYE IRRIGATOR.

By JOHN WARD COUSINS,

Senior Surgeon to the Royal Portsmouth Hospital, and the Portsmouth and South Hants Eye and Ear Infirmary.

THE treatment of contagious disorders of the eye has often proved disastrous to both surgeons and nurses, and many instances have occurred of serious injury and loss of sight.

Now this little contrivance has been designed to give protection to the operator, and also to secure rapid and thorough irrigation of the conjunctival sac. It discharges a double current of lotion with sufficient force to completely cleanse the eye without any risk of splashing and scattering the dangerous secretions. The instrument consists of two metal tubes which are at one extremity bent, but at an acute angle, and united by a short tube which is perforated with several holes on the convex edge; at the other extremity they are joined together and form a short tube to which the india-rubber tube of the glass receiver is attached. (See Fig. 1.)

**DIRECTIONS FOR USE.**—The irrigator must first be carefully introduced under the upper lid, and then held between the thumb and finger of the left hand, and the lid gently elevated, at the same time the right hand raises the glass receiver containing the lotion. The full stream caused by the double current quickly washes out the upper palpebral sinus. The irrigator should then be removed and introduced under

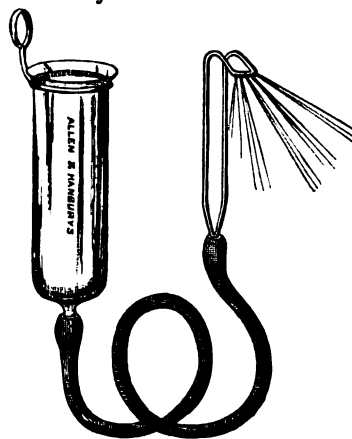


FIG. 1.

the lower lid, and the washing repeated. The waste fluid can be conveniently collected in a small bowl placed on the side of the patient's head. In cases of contagious ophthalmia the sound eye must be protected by an aseptic pad during the operation.



FIG. 2.

The instrument has been neatly made for me by Messrs. Allen and Hanbury, and with it compressed discs of sulphate of zinc, nitrate of silver, perchloride of mercury, boracic acid, and sulphate of aluminium can be obtained ready for immediate use.

### A MODIFIED ORMSBY'S ETHER INHALER.

THIS well-known inhaler has been modified by Mr. Lane Joynt, of the Meath Hospital, and, while preserving the principle of the original Ormsby's Inhaler, has been made capable of thorough sterilisation as far as is possible for any such contrivance.



FIG. 1.

The face-piece is identical with Barth's pattern used on gas apparatus, Clover's inhaler, &c., and is attached to the body of the inhaler by a slip joint, so enabling the anaesthetist to use larger or smaller sizes for adults or children as required. (v. fig. 1)

The cage for holding the sponges also fits into the body by a slip joint,

so that the sponges can readily be removed for cleaning. The body is made of gun metal and plated, and the air valve and ether tube so rarely of use in the older form has been done away with. Ether can be poured either directly through the face piece or on to the sponges by removing the body. In the latter is a cup, on the principle of the unspillable inkpot, to prevent any surplus ether running on to the patient's face. Every

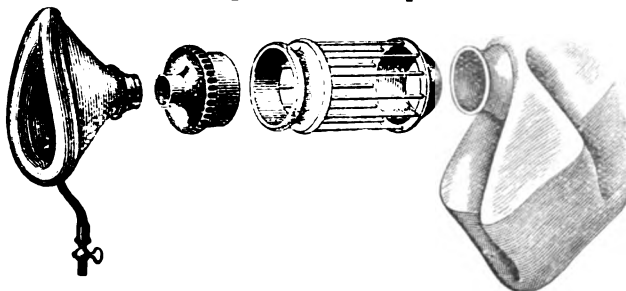


FIG. 2.

part of the inhaler can be reached by the finger for cleaning. This is a matter of the greatest importance, as will readily be seen when it is borne in mind that the instrument is used for varied cases, and may be rendered septic by the breath and expectoration of the patient. Many operators, including Professor Kocher, of Berne, to prevent the possibility of a dirty inhaler infecting the wound, hang a towel on a frame between the head and trunk.

The inhaler is manufactured, on modern aseptic lines, by Messrs. Smith and Shepherd, Stephen's Green, Dublin.

## Clinical Records.

### CANCER HOSPITAL, BROMPTON.

#### Case of Cystic Sarcoma of the Right Ovary Removal —Recovery. (a)

Under the care of F. A. PURCELL, M.D., M.Ch.,  
Surgeon to the Hospital.

THE specimen shown weighed, twenty-four hours after removal, 7 lbs. 15 ozs. Its circumference, measured at its greatest diameter, was 26½ ins., and its least, 18 ins.

Eliza C., at. 52, single, a prison official, was admitted to the Cancer Hospital, Sept. 24th, 1901. She stated that since the menopause, which occurred six years previously, she had lost nothing; that prior to this she had always suffered from dysmenorrhœa, and that during the ten years immediately preceding the menopause the menstrual discharge had been more copious than in earlier life. For five or six years she had been growing stouter. She had suffered from abdominal pain, however, for a considerable time before any swelling became evident. The tumour, when first detected, was about the size of a hen's egg. She had also experienced a feeling of weight in the abdomen, and this had become more noticeable during the last two years. The bowels and bladder had been normal.

The patient was observed to be well nourished, and to be unable to lie flat on account of the dyspnoea produced. The abdomen was much distended, the superficial veins enlarged, and the umbilicus flattened. A movable tumour, about the size of a football, was situated in the right hypochondrium, extending, however, across the middle line and three inches above the umbilicus. It was hard generally, but cystic in parts. A good deal of ascitic fluid, the presence of which denoted the malignant nature of the growth, masked its extent laterally. The uterus was felt, per vaginam, to be drawn up, but to be separate from the tumour. The sound passed 2½ inches. The heart, kidneys, and liver were normal.

On October 2nd, the patient being under ether, the abdomen was opened in the middle line. The omentum, adherent in many places to the tumour, was peeled off and ligatured. The pedicle, four to six inches in breadth, was secured in sections, divided, and the stump covered by peritoneum. Several openings which had been made in the omentum were closed with catgut, any tags present were cut away, and all bleeding points secured. The ascitic fluid was cleaned out, the left ovary examined and found normal, and, finally, the abdominal wall was closed in the usual way. The patient made an uneventful recovery, the temperature never rising above normal.

## Transactions of Societies.

### CLINICAL SOCIETY OF LONDON.

MEETING HELD FRIDAY, NOVEMBER 8TH, 1901.

MR. HOWARD MARSH, F.R.C.S., President, in the Chair.

DR. MOYNIHAN ON

THE OPERATIVE TREATMENT OF CANCER OF THE PYLORIC PORTION OF THE STOMACH.

An examination into the records of cases of recurrence of malignant disease of the stomach after operation shows that the return of the growth is almost always local, in the stomach wall at or near the line of section, or in the glands or lymphatic vessels which drain the affected area. It has been estimated by Hemmeter that recurrence occurs in 99 per cent. of cases submitted to operation. In order to perform an operation which shall prevent recurrence we must base such operation upon a knowledge

(a) British Gynaecological Society, October 10th, 1901.

(a) of the mode of invasion of the stomach by the primary growth, and (b) of the lymphatic distribution in the stomach and of the position of the glands into which the vessels drain. The researches of Borrmann and Cuneo have shown that the most common point of origin of carcinoma in the stomach is 2-4 cm. from the pylorus, on or near the lesser curvature. From this point the disease spreads gradually, but more rapidly and to greater extent towards the body of the stomach than towards the duodenum. On the stomach side the growth is not equal in all directions; there is a pronounced tendency for the induration to spread towards the curvatures. Towards the duodenum the spreading is slower and invariably less extensive. If sections are made at the edge of a malignant neoplasm and the slides examined, the following condition will be found: The edge of induration corresponds to the limit of growth in the mucosa. In the submucosa the growth extends much further in a solid unbroken mass, beyond the edge of this mass isolated nodular deposits of growth extend, becoming smaller as their distance from the tumour increases. The serous and serous coats are implicated approximately to the same extent as the mucosa. The lymphatic glands of the stomach are situated chiefly along the vessels. 1. The coronary group lies along the lesser curvature. The glands are continuous at the origin of the coronary artery with those along the upper border of the pancreas. 2. The hepatic group lies along the hepatic artery, and some of its members lie along the pyloric artery. The glands of the greater curvature lie along the right gastro-epiploic artery. At the pylorus they are numerous and close together, and pass behind the stomach to the head of the pancreas. The lymphatic vessels draining into these glands pass very obliquely in the walls of the stomach. Three chief lymphatic areas of the stomach may be described. An area along the lesser curvature; an area along the greater curvature; an area comprising the greater tuberosity of the stomach extending up to the oesophagus and on the greater curvature as far as the limit of supply of the left gastro-epiploic artery (as far as the gastro-splenic omentum). In cases of malignant disease of the pyloric portion of the stomach, the growth extends in the direction of the curvatures, and the glands of the first two groups are affected, and the glands of the third group and the area which they drain escape. This latter area may be looked upon as an area apart, as one into which extension very rarely occurs, and as one therefore whose lymphatic vessels and glands remain healthy. The term "isolated area" may well be employed to describe it. Upon the following facts an operation should be based: 1. Malignant disease of the stomach commences most often near the pylorus, just below the lesser curvature. 2. From its point of origin it spreads most widely in the submucosa, and chiefly towards the cardiac end of the stomach. 3. On the duodenal side it spreads tardily and never extensively. 4. The drift of the growth is towards the curvatures. 5. The lymphatics draining the affected area pass to glands lying along the coronary and pyloric arteries above, and the right gastro-epiploic and gastro-duodenal arteries below. 6. The greater tuberosity of the stomach (the "isolated area") is very rarely involved. In order to ensure complete removal of the primary growth of the infiltrated lymphatic vessels, and of the glands into which those vessels drain, it will be necessary to remove the stomach as far up on the lesser curvature as the point of abutment of the coronary artery, and on the greater curvature as far as the gastro-splenic omentum, and to remove the first portion of the duodenum. In order to make the operation simpler and quicker, a preliminary ligature of the coronary, the pyloric, the gastro-duodenal, and the left gastro-epiploic is performed. After removal of the portion of the stomach, the anastomosis between the "isolated area," and the small intestine may be made by end-to-end approximation. Kocher's method, or suture of the cut ends, and the performance of a separate gastro-enterostomy. The coronary artery is ligatured first, and is found as it lies in the "ligament of Huschke," the *faix coronaria*, whose folds enclose it. The position of the artery can be defined by lifting up

the liver and pulling the stomach downwards and outwards until a ridge is raised up in the peritoneum by the underlying vessel. The pyloric and gastro-duodenal are best ligatured as they leave the hepatic artery. The hepatic can be found just above the pylorus, and is made clearer by dragging the pylorus downwards and to the right.

Dr. PEE-SMITH, discussing the comparative frequency with which different parts of the stomach were attacked, observed that the smaller curvature was much more frequently the seat of cancer than the greater curve. Incidentally he remarked that it was a very rare thing for carcinoma of the pylorus to spread into the duodenum though it often spread in the opposite direction. He admitted that the surgeon was, as a rule, called in far too late, and he insisted on the importance of physicians having earlier recourse to their assistance. The next best thing to pylorotomy, he said, was simple short circuiting which relieved the most urgent symptoms, especially in the cases in which these were due not so much to the cancerous growth as to the mechanical obstruction which it caused. Moreover, this operation improved the patient's condition, so that the graver operation might, if thought well, be proceeded with later on, with much greater chance of success.

Dr. NORMAN MOORE pointed out that large secondary growths were unknown in connection with cancer of the stomach, and this constituted a point in favour of operation. He had not seen a single case of cancer of the pylorus extending into the duodenum in the course of nine years' post-mortem work at St. Bartholomew's, though he had met with one or two since. Out of thirty cases there were eleven in which the whole wall of the stomach was involved, so that no particular area could be regarded as exempt. He classified cancer of the stomach in three groups (1) those in which there was a marked tumour; (2) those in which the walls were more or less infiltrated, even involving the terminal part of the stomach, and (3) cases in which the cardiac end and greater curvature were involved. He mentioned also cases in which cancer developed on the site of an old ulcer. In fourteen of the thirty cases there were growths in the liver, often very small and not perceptible during life. In some the secondary growths were on the under side of the diaphragm, and in about a third the lumbar glands were enlarged. The average duration of life in cancer of the stomach was about eighteen months.

Mr. CHARTERS SYMONDS said his experience in operations on the stomach had been somewhat disappointing so far as effecting a cure was concerned. Out of about twenty cases of cancer of the pylorus there was only one in which he had felt justified in attempting pylorotomy, and even then he found it impossible to remove all the disease. In many of these no tumour was perceived clinically. In his cases it was quite impossible to make an end-to-end junction, and the disease must be very limited for this to be possible. In none of his cases was there any secondary growth in the liver. What surgeons wanted was earlier diagnosis.

Mr. A. BARKEE questioned whether it would ever be possible to arrive at an earlier diagnosis, and in any case they had no guarantee against recurrence. He did not believe that the duration of life was materially increased by pylorotomy, and even when it appeared to prolong life they had to allow for the fact that the malignancy of these growths varied within very wide limits so they could not be sure that the pylorotomy was to be credited with the result.

Dr. HABERSON divided these cases into two groups, viz., those which produced obstruction with the classic symptoms, and the cases which simulated gastric ulcer, due to malignant disease in the neighbourhood of the pylorus, not causing obstruction, yet giving rise to extreme dilatation of the stomach by setting up spasm.

Mr. BALLANCE compared the excellent results he had seen in Germany from these operations with the results obtained in this country, and asked why it was that the latter were inferior. In England it was but too often impossible to attempt a radical operation on account of the extent of the disease. It was impossible for them to rest satisfied with the results of the present methods

of treatment of carcinoma of the stomach. There was a lack of knowledge which prevented their making a diagnosis early enough to admit of successful intervention. He suggested that physicians, instead of waiting for the production of a definite tumour, should get the surgeon to make an exploratory incision which would show what was wrong.

Mr. MAKINS observed that the feeling of late was against the removal of pyloric growths. He referred to the case of a young woman with a limited growth of the pylorus which he removed with about a third of the stomach. She did splendidly for three months when dilatation recurred, and she died seven months later. He regretted that in this case he had not done gastro-jejunostomy. He questioned the desirability of removing many intestinal growths which it was at present the practice to remove, and he doubted if these patients lived longer than if they had been merely short-circuited.

Mr. MOYNIHAN, in reply, pointed out that in 70 per cent. of the cases the growth was in a part of the stomach, which admitted of its removal. With respect to diagnosis, he said that with a patient under medical treatment for gastric trouble at an age when one might expect to meet with cancer of the stomach, and when there was an absence of hydrochloric acid—a very important point in their estimation—then, whatever the physical signs and clinical condition might be, it was their practice to advise an exploratory incision. This had permitted them to obtain cases at an earlier date than elsewhere. Even in the early stage, however, the radical operation might not be permissible, because the disease might already have got beyond the limits of successful removal. He joined issue with Mr. Barker in respect of his view that life after gastro-enterostomy was at all comparable with life after partial gastrotomy or pylorotomy. Statistics showed at least one year clear gain in favour of the latter. The improvement after gastro-enterostomy was great and immediate, but was quite ephemeral. He suggested that the attitude of surgeons towards these operations was their attitude of some years since towards operation for cancer of the breast. Gradually they had extended the limits of that operation, and no doubt, as their knowledge increased, they would do the same in regard to operations for cancer of the stomach. He believed that, if attacked early by an operation on the lines he had described, they might hope in the future to obtain far better results than had been the case hitherto.

#### OBSTETRICAL SOCIETY OF LONDON.

MEETING HELD WEDNESDAY, NOVEMBER 6TH, 1901.

Dr. PETER HORROCKS, President, in the chair.

##### GNORRHOEAL PELVIC PERITONITIS.

Mr. J. BLAND-SUTTON made a short communication on this subject. The patient, *et.* 22, presented a history of appendicitis. On opening the abdomen on the right side the appendix was found adherent to the right ovary, which was cystic and contained pus. The tube of the same side also contained pus. These were removed after the separation of many adhesions. The appendages of the other side were healthy and were left. Suspecting that the condition was due to gonorrhoea, the vulva was examined, and found to be the seat of yellow muco-pus. The specimen was at once wrapped in warm sterilised Gamgee tissue, and within forty minutes was in the hands of Mr. A. G. E. Foulerton, who reported that the micrococcus gonorrhoea was demonstrated both by microscopical examination and by bacteriological culture.

Dr. DRUMMOND ROBINSON made some observations on the paper.

##### TUBAL MOLE WITH (?) ENCYSTED HEMATOCELE.

Dr. W. S. HANDLEY showed this specimen, and read notes of the pathological conditions found. The clinical features of the case had already been reported by Mr. Alban Doran, who had operated on the patient. One feature of special interest was that the gravid tube lay in front of the uterus, in the uterovesical pouch, the

uterus itself being retroverted. The specimen consisted of two clot-containing sacs, one of which was clearly the dilated tube, communicating by a narrow aperture, which appeared to be the abdominal ostium of the tube. Dr. Handley described the microscopic appearance of the wall of the distal sac, which presented the characters of an encysted hæmatocele; and proceeded to discuss the probable mode of its formation. He considered it probable that a layer of viscid blood situated at the ostium tubæ had become expanded by pressure and by fresh blood within the tube, so that in its production the hæmatocele might be compared to a false aneurysm, or to a glass bulb blown with a blow-pipe. He therefore suggested for it the term "hæmodynamocele."

Mr. ALBAN DORAN remarked that the gravid left tube in this case was not only in front of the uterus, but actually lying in front of the right appendages, and had contracted an attachment to the vermiform appendix.

Dr. HERBERT SPENCER suggested that the position of the tube might be congenital. He once found the Fallopian tube of one side lying in front of the uterus in a new-born child. The mode of origin of the hæmatocele suggested by Dr. Handley was interesting, and received some support from a case he had seen in which, during an operation for an ovarian dermoid, the tube, which was tuberculous, had a small blob of reddish mucus projecting from its open end. This condition might constitute a stage in the formation of a tubo-ovarian cyst.

Dr. W. S. A. GRIFFITH observed that if the uterus was retroverted, it was not necessary to invoke any special explanation of the position of the tube, which would naturally enlarge in the direction where there was the most room. A similar position was not very uncommon in the case of ovarian tumours.

Mr. BLAND-SUTTON said that the presence of any tumour in front of the uterus introduced a puzzling feature into the diagnosis. He had himself seen two or three cases in which a gravid tube lay in front of the uterus.

Some remarks were also made by Dr. LEWERS and Dr. LOCKYER, and Dr. HANDLEY replied.

##### FIBRO-MYOMA OF THE BROAD LIGAMENT.

Mr. ALBAN DORAN showed a fibro-myoma of the broad ligament associated with an ovarian cyst. The patient, *et.* 44, was found to have an ovarian tumour, and a second tumour was discovered low in the pelvis. After the removal of the ovarian cyst, which contained over ten pints of chocolate-coloured fluid, the second tumour was found to be a fibro-myoma arising within the layers of the mesometrium, quite distinct from the uterus. It was enucleated, and weighed 2½ lbs. It was a true retro-peritoneal fibro-myoma. Mr. Doran demonstrated on the black-board that tumours arising in the mesosalpinx, although anatomically retro-peritoneal, were not so clinically or surgically; whilst tumours in the mesometrium were anatomically, clinically and surgically retro-peritoneal. A parallel was to be found in the case of mesenteric cysts, which, like those of the mesosalpinx, were only anatomically retro-peritoneal, whilst the cysts which corresponded to mesenteric tumours lay quite posteriorly where the layers of the mesentery diverged from one another.

Dr. HERBERT SPENCER asked whether fibromyomata of the broad ligament were as liable to degeneration as those of the uterus?

Dr. W. S. A. GRIFFITH said that Pick, of Berlin, contended that in broad ligament myomata adenomatous structures could generally be found, derived from Wolffian duct remains; and he asked whether any such structure had been found in this instance?

Mr. BLAND-SUTTON said that the pathology of retro-peritoneal fibromyomata in the mesometrium must be the same as that of such tumours in other retro-peritoneal situations, for instance, behind the kidney; and it did not seem to him that there was any evidence that they were derived from glandular vestiges. Von Recklinghausen attributed the origin of myomata in the uterine cornua to Wolffian remains; but his theory did not extend to broad ligament myomata.

Mr. ALBAN DORAN, in reply, said that broad ligament myomata appeared to be subject to much the same degenerations as those in the uterus. The microscope showed no trace of glandular structures in the present tumour, which showed the features of a pure fibro-myoma.

The following specimens were also shown:—

By Dr. A. H. N. LEWERS.—A uterus removed six years ago on account of squamous epithelioma of the cervix, the patient being still alive and well.

By Dr. A. L. GALABIN.—A papillary ovarian cyst, associated with an accessory ovary on the same side.

By Dr. T. W. EDEN.—A fetal monstrosity of the variety known as cyclops.

Mr. ALBAN DORAN and Dr. CUTHBERT LOCKYER read a paper on

SLoughing FIBROID OF THE LEFT UTERINE CORNU :  
ABNORMAL RELATIONS.

The specimen was from a single woman, *æt.* 30, subject for a month to symptoms of pelvic inflammation with fever. There was an irregular movable mass in the left fornix, rising into the left iliac fossa, and connected with a small anteflexed uterus. Mr. Doran performed supra-vaginal hysterectomy, removing the uterus and tumour with the left appendages; the right tube and ovary were spared. The patient recovered. The tumour, five inches in its long diameter, was much larger than the uterus, projecting outwards rather than upwards from that organ. It was a true fibro-myoma in a necrotic condition, and adhered to intestine and omentum at its blunt-pointed outer extremity. This degenerative change apparently accounted for the febrile symptoms. At first sight the tumour simulated a fibroid in an undeveloped uterine cornu, but the Fallopian tube and ovarian ligament rose posteriorly, and not externally, and were attached to a deep groove between the uterus and the tumour. The left round ligament arose from the under surface of the tumour somewhat posteriorly, passing under it and forwards to the inguinal canal. A tumour with somewhat similar relations to a uterus much smaller than itself had recently been figured without any clinical history by Doederlein in Kustner's "Kurzes Lehrbuch der Gynäkologie" (fig. 146). This outward growth of a fibroid of the cornu without outward displacement of the corresponding tube and ovary was very unusual. The sloughy state of the tumour demanded its removal, and the uterus could not possibly be separated from a growth of this kind, so that it was also removed.

The paper was briefly discussed by the President, Dr. Lewers, and Dr. Lockyer; and Mr. Alban Doran replied.

BRITISH LARYNGOLOGICAL, RHINOLOGICAL,  
AND OTOLOGICAL ASSOCIATION.

ANNUAL GENERAL MEETING HELD ON NOVEMBER 8TH.

The President, Mr. MAYO COLLIER, F.R.C.S., in the Chair.

Mr. LENNOX BROWNE showed the Nernst electric lamp as one giving a far whiter light than any in present use.

Mr. MAYO COLLIER showed (1) a case of malignant disease of the pharyngeal wall, which was inoperable, and it was proposed to submit the patient to electrical treatment by Dr. Macintyre, of Glasgow; (2) a case of abscess of the maxillary antrum, associated with facial paralysis, which had subsided promptly after surgical treatment; (3) a case, in the person of an Army surgeon, who was present and spoke on his own case, in which asthma had been relieved after the removal of nasal polypi.

Mr. CHICHELE NOURSE showed a case in which a laryngeal growth had disappeared after the removal of nasal polypi.

Mr. LENNOX BROWNE remarked on these last two cases and said that although they were by no means unique, it was useful to record them, and he trusted that such cases would be always brought forward in view of the fact that quite recently doubts had been thrown on the importance and frequency of asthma and other diseases arising as nasal reflexes, notwithstanding that

they had been accepted by observers of repute all over the world.

Dr. BARK, while accepting these cases as reported, reminded the Fellows that not all were cured.

Dr. P. H. ABERCROMBIE showed a case of black tongue, from which Dr. Wyatt Wingrave had prepared microscopic slides and furnished a bacteriological report.

Mr. LENNOX BROWNE made a short communication on the preliminary and after treatment of operations on the mouth and fauces, insisting on (1) preliminary antiseptic washes, (2) sterile instruments, (3) complete rest of the parts and of the body generally after operation, (4) the use of mouth washes, by means of the throat syringe, instead of gargles, and (5) the non-administration of internal drugs, such as the bromides, which might cause skin eruptions liable to be mistaken for symptoms of septic infection.

Remarks were made by Dr. HASLAM, Dr. WYATT WINGRAVE, and the PRESIDENT.

Dr. MACINTYRE then delivered his Presidential Address on "The Application of Physical Science to the Surgery of Diseases of the Throat and Nose." This was illustrated by the exhibition of many instruments, and by lantern photographs.

The following office-bearers were elected at this meeting:—President: Dr. John Macintyre, of Glasgow. Vice-Presidents: Dr. Greville Macdonald, London; Dr. Walton Browne, Belfast; Dr. Hillis, Dublin. Council: Mr. Mayo Collier, Dr. Culver James, Mr. Claud Wcakes, Mr. Atwood Thorne, Dr. Woods, Dublin; Dr. Kelson. Treasurer: Mr. Lennox Browne. Secretaries: Mr. Chichele Nourse and Dr. P. H. Abercrombie.

SHEFFIELD MEDICO-CHIRURGICAL SOCIETY

THE First Meeting of the Session was held OCTOBER 10TH, when the President, Dr. C. H. WILLEY, delivered an address on the "Ætiology of Some Forms of Gastric Dilatation."

The Second Meeting held OCTOBER 24TH. Dr. C. H. WILLEY, the President, in the chair.

Mr. FYE-SMITH brought up the case of unilateral congenital displacement of hip which he had shown last February. The displacement had been reduced by Lorenz's method of manipulation under an anæsthetic, and the hip had been kept for nearly four months in a plaster of Paris case. The deformity and limp had now disappeared, and a second skiagraph showed practical symmetry.

Mr. EDWARD SKINNER showed specimens from a case of cancer of the lung.

Mr. SCOBIE exhibited specimens from a case of lymphadenoma, shown last session.

Dr. SINCLAIR WHITE showed (1) a post-rectal dermoid containing bone; (2) an unruptured tubal gestation; (3) a dilated vermiform appendix removed from the sac of an inguinal hernia.

Dr. STANLEY BISELEY showed a case of dislocation of the lens in both eyes.

Dr. ARTHUR HALL showed the following cases:—(1) Primary spastic paraplegia, in a man, *æt.* 39. Five years' duration. No history of previous disease. Had been in the army. Gradual loss of power of walking, with slight pains in back and legs. Extreme myotatic irritability. No sensory symptoms. No atrophy. No ocular affection. Some difficulty in controlling urine and faeces. Marked spastic gait. (2) Two cases of trade eczema. Both patients, middle-aged women, who work as scotch brushers. One case, although working under the same conditions for twenty years, only commenced to suffer a few months ago. The other commenced within a few weeks of beginning her present work eight months ago. The irritant appears to be the "sour beer" with which they brush the silver goods. (3) A case of lupus vulgaris and lupus erythematosus in the same individual. Lupus began at the side of the nose eight years ago, and shortly after she had been nursing a woman who died of consumption. At the present time the lupus is quiescent, but there is some destruction of both *alæ nasi*, and the upper gum is affected. Much later than the lupus she had an outbreak of lupus erythematosus over both cheeks and nose.

This has twice disappeared completely and recurred. At the present time the lupus erythematosus has an extensive "butterfly" distribution. The patient is about twenty years of age.

Mr. SNELL introduced a young woman, *æt.* 19, with what appeared to be a vascular growth in the lower and inner wall of the orbit. There was marked ptosis, and the surface of the sclerotic below was covered by a *nævus* condition of vessels. The history only extended back a few months, and the condition was progressing. There was no history of injury.

Mr. PYE SMITH read a paper entitled "Four cases of Gastric Ulcer, in which operation was performed, together with one case not operated on, two cases operated on by others, and three cases of exploration for suspected perforation."

#### MIDLAND MEDICAL UNION.

ANNUAL MEETING HELD AT NOTTINGHAM, OCT. 23RD.

The President, J. G. SHEA, F.R.C.S.I., J.P., in the Chair.

AFTER a short address by the PRESIDENT,

The Hon. Secretary, Dr. HOUFTON, of Shirebrook, dealt with the work done during the past year.

#### THE QUESTION OF MEDICAL FEES.

He described the origin and constitution of the Association, their first efforts being to try and establish a minimum fee for midwifery cases of one guinea, and to establish a minimum rate for friendly societies of five shillings per member per annum, adults and juveniles. In regard to the midwifery question, they had met with conspicuous success, for, with the exception of a district in and about Eastwood, Notts, and a few cases involving contract midwifery, the guinea fee is now universal throughout the two counties, and the only reason the particular district mentioned is exempt is that one of the practitioners, whilst not attending cases for less than this fee himself, allows his assistants to do so. In regard to the contract midwifery question the Union agreed to support any member who cared to apply for the increased rate of payment for these particular cases. Dr. Rainsbury, of Skegby, who held a colliery appointment to the Teveral Colliery Club, commenced to charge the increased midwifery fee, and, in consequence, was threatened by dismissal from his appointment. A deputation waited upon the club committee to point out the reasonableness of the fee, and asking them to give the matter their careful consideration. However, they sent Dr. Rainsbury an agreement to sign in which he should bind himself to charge a sum of 10s. 6d. for members' wives attended by him in their confinements. This he refused to do and, in consequence, was served with three months' notice. The Colliery Club then advertised for a surgeon, the Union advertised warning men from accepting the post, and through the courtesy of the editors of the medical papers no more advertisements were inserted from the Colliery Club. The club, however, managed to secure a medical man who agreed to accept the appointment, but he never went to take up his appointment. The result was that after Dr. Rainsbury's notice expired, on June 25th, 1901, the club was without a medical officer. This state of affairs has continued up to the present. Dr. Rainsbury has been attending the club members, their wives, and children at private rates. We have been informed that the club has secured another medical practitioner, who insisted upon being given the appointment of a neighbouring practitioner as well under the same club committee, viz., that of a practitioner who had been asked to accept Dr. Rainsbury's appointment and had refused. This practitioner has received three months' notice from the club, but up to date no medical man had arrived to take up his duties. In regard to the friendly society question no very great result can be recorded up to date. The resolution suggesting a minimum of 5s. per member per annum has been rescinded, except in regard to new clubs or clubs changing medical officers, and a sum of 4s. substituted. But before enforcing this the Chesterfield branch chose delegates to meet delegates from the Chesterfield and

District General Friendly Societies' Council to see if affairs could be arranged amicably. Up to date the Friendly Societies' Council have offered a sum of 4s. for adult members and 2s. 6d. for juveniles, but this has not been accepted by the Union, and the matter is still under discussion. Several cases of difficulty between clubs and their surgeons have also been settled satisfactorily, and the founders of the Union might feel themselves amply repaid for their trouble and work in the fact that they have raised the feeling of *esprit de corps* of the profession in this district.

On the proposition of Dr. MUTCH, seconded by Dr. W. E. M. WRIGHT, the following resolution was carried as an alteration of the rules:—(a) Members are asked to guarantee a sum of five guineas, or multiple of five guineas, so that in the event of indemnity being required, the money may be called up in the proportion promised; (b) Subscription to this fund is not compulsory; (c) In case any member should apply to be indemnified from this fund, who is not a subscriber to it, the granting of relief to such member shall be left with the President and Vice-President to decide whether there are special circumstances entitling the member to such relief. (d) The control of this fund shall be left with the Council of the Union.

## Special Articles.

### CAPITAL PUNISHMENT.

THE death of the assassin of President McKinley on the 29th ult. has so far satisfied the acknowledged demands of civilised government, one of the principal functions of which is the protection of life. Whether the widely-recognised power of the law to deprive every murderer of life has ever acted as a deterrent of sufficient efficacy to justify the dreadful responsibility of the infliction of capital punishment, is a question which we expect soon to hear sharply discussed in our various civilised democracies. We have passed by degrees from the horrors of the stake, the torture-chamber, of braying in a mortar, of flogging to death, of crucifixion, of impalement, of tearing to pieces by wild horses, of the lethal embraces of the "Jungfrau" of Nuremberg, through decapitation and hanging, and many other modes of deprivation of life, down to the practically scientific and decently humanitarian "electrocution" of the present day. That this latter is a distinct tide-mark in the advancing current of civilisation cannot, we think, be questioned. Still the shrinking feeling which the idea of exposure to a sharp electric shock elicits in most persons makes it very doubtful whether the approach of death by this method is not more dreaded than that by decapitation or hanging. There can be no question regarding the (*quam proxime*) instantaneous occurrence of death in execution by the guillotine. The severance of head and trunk, the cleavage of the cerebro-spinal axis close to the medulla oblongata is absolutely efficient. And the accompanying hæmorrhage, so entirely uncontrolled, would by itself be as effective, although not quite so rapid, a factor in the production of the fatal result. But in death by hanging the conditions are more complicated. It is not, we believe, very generally known that in the good old days of unlimited monarchical power when executions—especially political ones—were carried out on so large a scale, when a rebel was drawn on a hurdle, hanged, disembowelled, beheaded and quartered—hanging was used as an *anæsthetic*. From time immemorial in some of the Eastern nations, partial strangulation was so employed before important surgical operations. And in the execution of an English rebel the hanging was by "short-drop," and the culprit was cut down while still alive. He was then ripped open, the heart and bowels were torn out and burned "before his face" in a fire made ready for the purpose. In Ireland, where the executions were sometimes conducted on an epidemic scale, the "long drop" was very generally used; it saved time and trouble. The present humanitarian age requires that the legal death of a murderer be attended with a minimum of physical suffering. And if the drop be duly regulated, death must

be practically instantaneous. The first important step in the amelioration of this form of capital punishment was made in Ireland. A scientific philanthropist of that country, who was also both a medical man and a mathematician, conducted a series of experiments on dead bodies with the object of calculating the length of drop requisite in each individual case to effect laceration of the upper part of the spinal cord, by procuring dislocation or fracture of one or more of the vertebræ close to the base of the skull. The net result of those experiments and the calculations based thereon, was that a certain number was fixed on, which, when divided by the number of pounds of the body-weight of the person to be executed, gave the number in feet of the length of drop required. Soon after the publication of this mathematical method of execution a case came on in a prison in Dublin, the visiting surgeon to which was a friend and admirer of its author. Accordingly, the culprit was weighed, the requisite sum in division was performed,—the quotient was fourteen. Result: The victim when dropped was decapitated by the rope. The author of the improved method of jugular suspension had overlooked the fact that while arithmetical numbers are fixed quantities, the resistance of animal tissue varies with the individual; and that, accordingly, two persons of the same weight may be formed of tissues of vastly different strength. He afterwards, however, made another fertile suggestion—of placing the knot of the rope under the chin of the culprit, instead of under the left ear as was the old traditional "Jack Ketch" custom. With a moderate drop this arrangement utilised the lower jaw as a lever whose agency fractured or dislocated the upper cervical vertebræ. The comment on the ghastly accident to which we have above referred, was, happily, a strong factor in the abolition of the brutalising spectacle of public executions.

The horrors of the execution of the weak-armed and weak-minded Damians for his "pen-knife scratch" of the skin of the worthless sensualist, Louis XV. of France, must elicit a sigh of relief when we contrast that event with the details of the execution of the successful assassin of the late President of the United States. There can be no doubt that while the law continues to wield the power of depriving a murderer of life, the exercise of this gloomy function can hardly be carried out with greater regard to decency and philanthropy than it was in the case of Czolgosz. Damians had his right hand and forearm roasted in a slow fire on the scaffold; portions of his flesh—in the most sensitive parts—were nipped off with red-hot pincers, boiling oil, boiling pitch, melted resin, melted wax, &c., were poured into the wounds; and, when life had ebbed so low that the perception of pain was obviously evanescent, his limbs were lashed to four wild horses who were then whipped in different directions. It is noteworthy that this well-arranged attempt to have him torn in pieces completely failed, so that the dismemberment was completed with knives. The wretched man was carved on the scaffold!

The "Jungfrau" of Nuremberg was another monument of the abused application of legal revenge. A gigantic female doll—massively constructed of wood and iron—opened vertically along one side, and presented a cavity adapted to the standing posture for a full-sized man. When the person destined by law to submit to the embraces of this "maiden" was placed standing therein, the door was firmly closed, and he was pierced by some half-dozen iron spikes projecting from the metallic lining of the latter, each of about six or seven inches long. Two of these were arranged for the orbits, one for the heart, and the others for various parts of the trunk. Reflections on the existence of such horrors, and on the frequency of their application to wretched humanity, must at least leave us with the assurance that, even with all its hurry and worry, the age we live in permits an existence at least more endurable than did the "good old times" which we have so fortunately escaped.

So far as we can inform ourselves regarding sensation of suffering, there can be no opportunity for its appreciation in electrocution. The discharge being sufficiently strong, all vital functions must instantaneously cease.

We remember a great deal of sensational newspaper comment on the first electrocution. Death was said not to have been instantaneous; a small cut on the finger yielded some blood. This result will always follow—for a couple of minutes, as the blood does not in any case coagulate *instantly* after death; and in all deaths by electricity coagulation is notably imperfect. Then, the repeated application of the current was followed by the smell of burning hair, of roasting flesh, &c. This must have been pure invention; good conductors, such as must have been used, do not so rapidly become heated. The only thing that could burn in such circumstances would be a spark, which could not form when the contacts were complete. Let us conclude, while expressing the opinion that physical suffering is practically annihilated by the employment of electrocution, by hoping that the necessity for the employment of even this humane agent in depriving a murderer of the first gift of his Creator, will steadily diminish as the years of our twentieth century roll on.

#### ANNUAL REPORT OF THE ROYAL COLLEGE OF SURGEONS OF ENGLAND.

We have received the Annual Report of the Royal College of Surgeons of England for 1901, containing also the notice that the annual meeting of Fellows and Members will take place on November 21st, at 3 p.m., when the report of the Council will be presented. The Report is a record of work done in the various departments from August 1st, 1900, to August 1st, 1901. The earlier pages are occupied with disciplinary matters, relating chiefly to the prosecution before the General Medical Council of a dentist at Bury St. Edmunds for using misleading titles when unqualified, although registered. This matter was investigated by the General Medical Council during their June Session, and its further consideration adjourned for the attendance of the offending dentist. One member was rightly removed from the College List in January for disgraceful conduct. This individual was a Mr. J. T. H. West, who associated himself with the Drouet Institute, an establishment which has been fully and completely exposed in our columns, in *Truth*, and other journals.

Working in conjunction with the College of Physicians, the College has been seriously considering whether any action is desirable to remedy the effect of the present regulations relating to the recognition of preliminary examinations on the entries of students to the examinations for the Conjoint diplomas. It appears from a memorandum prepared by the Committee of Management that in 1893, 1,973 students were registered, and in 1900 only 1,712. The net decrease at the examinations is 261 on the year. Such a serious decrease naturally calls for the consideration of the College.

An alteration has been made in the regulations for the Diploma of Public Health, in order to prevent the six months' laboratory course from overlapping by more than three months the period of study to be spent under a medical officer of health. These alterations are given *in extenso*. Certain alterations have also been made in the regulations for the Diploma in Dental Surgery.

Of the College prizes, two, the College Triennial Prize and the Walker Prize, have not been awarded. The Jacksonian Prize has been won by Mr. McAdam Eccles for his essay on "The Pathology, Diagnosis, and Treatment of the Diseases caused by and connected with Imperfect Descent of Testicle." We note with satisfaction that in the regulations for the Cartwright Prize, now under the control of the College, and awarded to dental surgeons, it is stated that a Diploma or Licence in Dental Surgery without a medical or surgical diploma or degree will not be a sufficient qualification. Such a proviso cannot but be beneficial to the advancement of the dental profession.

Among the gifts which have been bestowed upon the College during the year are included a bust of the late Mr. Henry Lee, and a portrait of the late Dr. Richard Neale, the well-known compiler of the "Medical Digest."

In the report of the Laboratories of the two Colleges it is highly satisfactory to note the large amount of re-

search work that has been accomplished during the past year. A large amount of antitoxic serum for the treatment of diphtheria has been prepared, no less than thirty-seven doses of 4,000 units each, and 28 928 doses containing 3,000 units each having been supplied. The work in other antitoxins has been equally great.

Turning now to the report of finance, we find that the gross income of the College for the past year is £26,104, being £893 greater than the previous year. This is chiefly due to the advance in the amount of fees paid by candidates for the Dental diplomas. The balance of income over expenditure amounts to £2,115, from this, however, must be deducted £490 for one half-year's rates, which has not yet been paid. On the other hand it must be borne in mind that the extraordinary expenditure for the year has amounted to £1,800.

The reports for the Museum and Library are in every way satisfactory, both departments showing improvement.

In March the College lost the services of a most devoted servant by the retirement of Mr. Trimmer from the office of secretary, after no less than forty-two years' service. In consideration of his long and valuable connection with the College Mr. Trimmer has been granted a pension.

The report closes with the usual balance-sheet and statistics of the examinations, and an obituary list, which shows that the College has been deprived by death of thirty-three Fellows and 450 members.

## Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, November 9th, 1901.

At the meeting of the Medical Society, Hr. Gluck showed three cases of

### RECOVERY FROM TUBERCULOUS PERITONITIS.

The three were just typical of the various forms of the disease. All were subjects of suppurative peritonitis in which recovery could not be brought about until large incisions had been made and even eventration performed, the exudation cleared out, and diseased portions resected. Hr. Gluck's investigations dated from the year 1861. They showed that animals could very well live twenty-four to forty-eight hours with an open abdominal cavity with eventration of its contents. Reposition was effected after two or three days, the animals remaining alive, whilst the control animals, for whom his special apparatus was not used, died with the familiar symptoms of loss of heat, sepsis, &c. The method of procedure had been adopted by surgeons of keeping the abdomen open, with free drainage of secretions.

Hr. J. Israel held that the method followed by surgeons generally was different from that of Gluck. Most surgeons did not treat the intestine; whilst eventrated, they generally made an incision with a view of relieving tension and of furnishing a serviceable method of draining. The procedure of draining the abdomen was much older than Gluck's. He himself considered Gluck's apparatus to be unnecessary. He had practised long-continued drainage both in children and adults in the most severe cases, and eventration had never been found necessary. Most patients recovered with complete closure of the abdomen with the exception of a few cases with carious patches, which naturally must be treated by tamponnade, wherein he saw no new principle. Gluck's procedure, moreover, resulted in large abdominal hernia.

Hr. Gluck maintained that his cases were so bad that they would have died if his particular method of treatment had not been put into practice.

### THE DIET TREATMENT OF EPILEPSY.

Dr. R. Balnit, in the *Ungar. Med. Presse*, gives an account of the great success he has himself obtained with the dietetic treatment of epilepsy. When it can be said that in an institution in which about thirty attacks per day occurred among the inmates, and that by diet treatment alone this total of attacks was reduced to two to three in the day, it may fairly be claimed that the method is deserving of some consideration. The method described is simplicity itself, but unfortunately there will be difficulty in carrying out the treatment in a trustworthy manner except in institutions where all is under control.

The first proposition is that a diet poor in chlorine can and should be carried out in all cases of epilepsy.

2. That it can best be carried out in a sanatorium.

3. That it should be strictly carried out in all cases until the disease has become thoroughly understood.

4. Along with the diet poor in chlorine a small quantity of bromine should be given.

5. That the bromine is best introduced in the food. It is recommended that two to three grammes of bromine made up in the bread in which the bromide is made to replace the usual sod. chloride be given daily.

6. The favourable effects of the treatment lie mostly in the increase of action of the bromide. Cases to which the bromine was given without deprivation of salt did not improve much, and deprivation of salt without the substitution of the bromide had little effect compared with that produced by the combined deprivation of sodium chloride and substitution of potassic bromide.

### THE TREATMENT OF ECLAMPSIA.

From October 1st, 1895, to October 1st, 1900, 143 cases of eclampsia came under observation in the Leipzig University Frauenklinik. In the same period there were 1,902 labours, so that the complications occurred in about 2 per cent. of the cases. In Olshausen's Klinik in Berlin there was a case in even 21.6 labours, equal to 4.6 per cent.

The treatment consisted in quick but gently emptying of the uterus under an anæsthetic. For eclampsia in the after-birth period the expectant principle was carried out. Manual removal of the placenta was only practiced in a single case. Dilatation of the cervix was effected either by gradual dilatation by means of elastic bags or by incision, or by both methods combined. The incisions were made by grasping the cervix or edge of the os by two Billroth's pressure forceps and cutting through between them. In this way the cutting is easier to do, and by leaving the forceps on for some little time the bleeding is usually slight. The incisions are not generally sewn up after delivery has taken place. With the foetal head high up and freely movable turning was generally preferred. When it was found that the child was dead either before or during delivery perforation was always effected. If the attacks followed one another very rapidly and no great amount of blood had been lost, venesection was performed. Along with the venesection saline infusions were made. Morphia and warm baths were given in a few cases. No fluids were given to the patient to swallow whilst unconscious, but the fauces were frequently washed out. The treatment described was carried out in all the writer's cases, and it did not fail in any instance. In a large



number of them the whole process of delivery was completed within the hour. The author acknowledges that the method has risks of its own, but maintains that such a serious condition as eclampsia justifies a certain amount of risk. The prognosis is much more favourable than in Cæsarean section. As regards maternal mortality he claims that it will compare favourably with that attending any other mode of treatment.

## Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, November 9th, 1901.

### THE RELATION BETWEEN THE CIRCULATION AND TONUS OF THE BOWEL.

At the Gesellschaft der Aerzte Pal drew attention to the altered condition of the bowel when the circulation of the blood is interfered with. In connection with this he related his experiments on animals with suprarenal extract which when injected into the veins determines a marked relaxation in the bowel.

In endeavouring to carry out these experiments with greater precision he found that compression of the aorta was not adapted for laboratory work owing to its mobility. Therefore, when one desires to demonstrate the behaviour of the bloodvessels in the small intestine in relaxation of the bowel it is necessary to curarise the animal. The suprarenal extract was afterwards injected, and the movements of the bowel carefully observed by the aid of an instrument which registered the varying curves of muscular movement. It was found that the circular and longitudinal muscles were enfeebled, and the peristaltic movement of the bowel abolished as if its nervous system had been destroyed. Morphia and suprarenal extract, however, have antagonistic effects on the bowel, probably owing to the special vascular action of the extract. If a segment of small intestine of a curarised animal be detached from the mesentery along with its nerve supply, splanchnic irritation will produce relaxation of the bowel with a cessation of peristalsis. From this it would appear that a contraction of the vessels of the bowel wall produces relaxation of the bowel itself, a fact which is not easy to explain. It has been suggested that this anomaly is due to some interference with the ganglionic apparatus. The bowel in this relaxed condition is not distended, but remains passive in medium contraction. Its peristaltic movement stands in direct relation to the blood circulation. If the vessels of the bowel contract so that stasis takes place in the veins the bowel becomes relaxed; if the contractions are feeble owing to the lowered stimulus of the splanchnic, the peristaltic wave does not cease altogether, although it may be modified, but if the extract be injected the result is reversed, both stimuli bringing the pressure of the blood to the highest point of pressure. There is no doubt about the vasomotor system exciting an inhibitory effect on peristalsis, but the phenomenon is not confined to this system of nerve supply. It must be remembered that the peristaltic movement is determined by the contents of the bowel itself, operating from within outwards, a fact which supports the hypothesis that atony of the bowel depends largely upon disturbed nutrition.

Biedl asked whether it was a fact that suprarenal extract acted directly on the intestinal ganglia.

### NEW TREATMENT OF CARCINOMA.

Loeffler has recently surprised the profession by a new treatment of carcinoma by injections of malarial blood, or by exposing the carcinomatous patient to the infected anopheles. His treatment is founded on the observation that in Central Europe carcinoma is increasing, while in the Tropics and in malarial districts generally carcinoma is on the wane. This is not a new idea, as a case of carcinoma recorded by Trnka in 1775 shows.

### LYSOL POISONING.

Burgl records two cases of lysol poisoning. One of the victims was only *æt.* 5 days, the other 8 years. These were given one teaspoonful of the undiluted fluid. Severe symptoms have been observed following the external use of lysol, the symptoms resembling those of carbolic poisoning. Burgl recommends thorough washing out of the stomach and bowels, followed by plenty of fluids to hasten the elimination of the poison from the blood.

### DIPLOCOCCUS SEMILUNARIS.

Klebs believes that the diplococcus *semilunaris* plays an important part in the organism affected with tuberculosis. It is constantly to be found on the tonsils of tuberculous patients, and must greatly impair the results of treatment, as it markedly reduces the resistance of the tissues. He relates many cases in which the diplococcus has effected more widespread destruction than the specific microbe of tuberculosis.

## The Operating Theatres.

### ST. THOMAS'S HOSPITAL.

GASTRO-ENTEROSTOMY.—Mr. BATTLE operated on a female patient, *æt.* 50, but looking considerably older, who had been sent to him by Dr. Waters, of Sheerness. The woman was pale, very thin and feeble, and her skin was wrinkled and parchment-like. She stated she had been suffering from pain in the upper part of the stomach for three months, and the doctor in the note that he sent stated that he could feel a small tumour in the epigastrium, and that in addition to the pain, she had vomiting after food and constipation. After admission, she was kept in bed for a time, and bismuth and morphia were given internally. This relieved the pain and checked the vomiting, so that she gained strength and appeared much better; but at the end of a week she again had a return of the sickness, so it was decided to operate at once. Through a median incision above the umbilicus, the stomach was explored, and the tumour discovered in the position of the pylorus. This was hard, firmly attached to the stomach, and surrounded the orifice like a ring. The glands were also enlarged, and it was quite evident that the patient could not undergo the necessary manipulations involved in the removal of the tumour had its general condition permitted of an attempt to remove it. It was decided, therefore, to do gastro-enterostomy, and attach the upper part of the jejunum to the anterior wall of the stomach. This was done by means of sutures only in the following manner: The small intestine was taken at the part where it comes round from the side of the spine and is attached. A sufficient length was taken from this spot, and a loop brought forwards and held in the wound with the por-

tion of stomach to which it was to be sutured. Continuous silk suture (No. 1) was passed after Lembert's method for about two inches, uniting the walls of the opposed structures in a somewhat curved manner. Precautions were taken to shut off the peritoneal cavity from the site of operation, and both stomach and small intestine were incised at an equal distance over about an inch and a half. A continuous stitch was then inserted so as to completely surround the two apposed openings. Very little escape of fluid took place. After the openings had been closed a second continuous stitch was inserted, which surrounded the inner line of suture at a short distance, and one or two reinforcing sutures were placed advantageously. The parts were washed with warm saline solution and the abdominal wound closed. Mr. Battle remarked that the advantages of this operation were obvious, and the relief which it afforded was very great. While the essential things required in any operation performed on patients suffering from this form of disease were that they should be capable of being quickly performed, and not of themselves to be particularly risky. He was glad to find that opinion was coming round to the advantage, against other forms of operation, of the anterior method of gastro-enterostomy, and of the method of suture over that of special apparatus. He had always been in favour of this method of operating, and invariably used suturing as above described. The methods of uniting intestine to intestine, he said, were very numerous and could be counted by the score, but the true solution of the successful operation consisted in careful preparation of the patient, a sepsis and rapidity of operation, combined, of course, with accuracy of apposition of the parts.

Six days after operation the patient was doing extremely well. When she recovered from the anæsthetic she was permitted to drink water at intervals, and on the following day careful feeding was commenced.

#### WEST LONDON HOSPITAL.

AMPUTATION AT HIP-JOINT FOR SARCOMA OF FEMUR.—Mr. SWINFORD EDWARDS operated on a girl, æt. 14, with the following history:—Two years previously she had had some slight pain in the left thigh, which was thought to be rheumatic, and which passed away after a short time. She enjoyed good health till nine months ago, when a doctor was called in on account of pain in the left thigh, which prevented her walking with comfort; the pain got worse, and the thigh began to swell. Her temperature at this time did not exceed 100. The case was looked upon as being possibly one of periosteitis. On admission to the hospital the child was completely bedridden; she was a weakly, sickly-looking girl, evidently suffering considerable pain, and she could not bear the limb touched. She lay on her back, with the left thigh externally rotated, abducted, and slightly flexed. The thigh itself was generally swollen, and appeared about four times the size of the opposite thigh. The skin over it was tense, and dilated veins running over the limb were a well-marked feature. The diagnosis of the case evidently rested between a new growth and a periosteitis; this was easily settled when an incision under ether was made into the swelling two days before, as there was no escape of pus, but a large quantity of blood, granulation

material, and broken down debris the finger; was passed into the medullary cavity about the level of the trochanters where the bone had undergone spontaneous fracture. The relieving of the tension by giving exit to so large a quantity of blood gave the child considerable ease from her pain. It being decided that the only chance of saving her life was to remove the limb, Mr. Edwards amputated by Furneaux-Jordan's method. As it appeared probable that the amputation would take unusually long because careful dissection had to be made to avoid cutting in to the new growth, and as the evidence had showed the patient to be highly vascular, the child's median basilic vein was exposed and the transfusion apparatus kept all ready to hand in case of emergencies. An Esmarch's tourniquet was entrusted to an assistant; it was placed below the crutch and made fast over the iliac crest of the corresponding side; its front portion passing across a rolled bandage acting as a pad for compression of the external iliac vessels. On severing the superficial and deep femorals it was found that hæmostasis was not complete; in spite of this but little blood was lost, thanks to the rapid and effective way in which the vessels were seized by Mr. Bidwell, who was assisting the operator. In spite of the fact that there was a spontaneous fracture, no difficulty was experienced in exarticulating, the head of the bone being levered out by the manipulations of the limb just as if there had been no fracture. The disease did not appear to have extended to the os innominatum. The patient having become pulseless, three pints of normal saline solution were injected into the already prepared vein with such marked effect that the girl when taken from the operating table had a better pulse than when she had been placed on it. Although the tourniquet did not appear to answer for the vessels in front of the limb, there was but slight bleeding from those in the posterior flap, so that but a few ounces of blood were lost during the operation. As it was feared that the effects of the saline solution might soon wear off, the transfusion apparatus was kept in its place in the vein when the patient was taken back to the ward, so as to be ready at a moment's notice. Mr. Edwards said that in a case of this kind amputation could not be so quickly performed as when it was done for tuberculous disease; he pointed out that he had to steer clear of the tumour, which was evidently a rapidly growing central sarcoma. A curious point, he remarked, was the ease with which exarticulation was performed in spite of the fact that there was a complete loss of continuity between the head and shaft of the femur. He had expected to have met here with a little trouble, and he had quite anticipated having to use the lion forceps in order to remove the head from the acetabulum. He was afraid that the prognosis was bad, although it was quite possible that the child might live for a full year, and this with comparative freedom from pain. No further collapse having set in after operation, the transfusion apparatus was removed on the following morning, and then it was noticed the patient was sufficiently well to amuse herself by reading a book. A week after operation she was doing well.

THE only title bestowed on the medical profession on the King's birthday last Saturday was a knighthood to Mr. George Anderson Critchett, F.R.C.S., Oculist to his Majesty.

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**The Medical Press and Circular.**

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, NOVEMBER 13, 1901.

**THE LESSON OF LONDON AND ITS WATER SUPPLY.**

It is needless to point out that the welfare of any community is inseparably connected with the purity and the sufficiency of its supply of water. In many different parts of the United Kingdom the right of providing particular districts with that prime necessity of life has been granted by Parliament to private trading corporations, who are thus obviously placed in possession of a valuable monopoly. With the growth of the critical municipal spirit, however, the modern citizen has come to recognise that the profit made out of the sale of water and of certain other monopolies, such as artificial lighting and transit might with advantage to himself be diverted from the pockets of private individuals and applied to the relief of local taxation. In other words, that he should own the monopolies himself. In some of the more advanced provincial towns of the United Kingdom the question has long been solved so far as water is concerned, by the construction of water systems on a scale that for size and completeness might compare with the famous aqueducts of ancient Rome. In London, however, the capital of the kingdom, the water monopoly remains in the hands of eight water companies, who possess therein a property of enormous value. These corporations have received their powers on certain conditions, as to pressure, purity, and supply, which have been time after time grossly violated. The recurrences of prolonged droughts year after year in the East End of London furnish an object-lesson as to the way in which a company can play fast and loose with its obligations and yet escape with impunity. Inquiries have been appointed time after time by Parliament, and their reports have demonstrated the defects of the present system and the inadequacy of the supply for the wants of a future generation, while at the same time they have approved the principle of purchase by the municipal authorities. These points have

been vigorously adopted in the policy of the London County Council, which was created in 1888, a body that represents the leaven of municipal enterprise and progressive prudence that has at length begun to permeate the population of the greatest and richest city in the world. So far their attempts to deal with the water problem have not been attended with conspicuous success. Indeed, it is not too much to say that the policy of the County Council has been met with determined hostility by the political party that is at present in power. The results of the conflict so far have been disastrous to the long-suffering Londoners, whose experience, it is to be hoped, will act as a warning to all municipal communities throughout the kingdom who have not been wise enough to secure the control of their water supply. During the last three months the addition to the Stock Exchange value of the Metropolitan Water Companies' ordinary stocks amounted to £1,800,000, in spite of the fact that nothing whatever has occurred to enhance their intrinsic value. A similar advance took place in 1879-1880, after the announcement by Mr. Secretary Cross of the intention of the Government to deal with the subject. Six years ago, so it is stated by the County Council, the whole matter of purchase could have been carried through for £6,000,000 less than would have to be paid to-day. That unearned increment has been due mainly to the obstacles placed by the Government in the path of those who at the last Council Election received an overwhelming mandate from the electors in favour of municipalisation. The County Council, however, have now shown their determination to bring matters to a crisis. At a recent meeting, by a large majority, they decided to reintroduce their own Purchase Bill in the course of the next Parliamentary Session. In the event of their proposals being either rejected or rendered impracticable by the party in power, the Council will be thrown back upon their own resources. It is, of course, impossible to predict at this stage of the weary controversy what action will in that event be taken by the municipal authorities. At the same time it will not be forgotten that strong reasons exist in favour of obtaining an alternative supply from the Welsh hills, which still hold a few watersheds available for the purpose that have not been already appropriated by other towns. The Thames water, from which London is mainly supplied, is extremely hard, and is contaminated by an enormous amount of sewage. Moreover, its resources are already overtaxed, and in the course of another generation the increased population of the metropolis will render the acquisition of large independent sources of supply imperative. Meanwhile the unearned millions multiply in the coffers of the water companies at the cost of the ratepayers of the metropolis.

**IS CANCER INCREASING IN FREQUENCY?**

In the Inaugural Address at the opening of the 182nd session of Jervis Street Hospital, Mr. Austin

Meldon, F.R.C.S.I., dealing with the question of cancer, brought under the notice of the profession some very striking statistics of the prevalence of this disease in these countries. The figures were derived mainly from the returns of the Registrar-General for Ireland, and are based on investigations which have been carried on in his office for some years past. An examination of these figures shows that not only has the rate increased, but that in the actual number of deaths recorded there is a corresponding increase. When, however, we come to examine the different age periods, we find that the increase is much more marked for the common cancer age—that is, between 35 and 75—than for the other periods. The question whether these figures indicate that cancer is becoming more prevalent or not in Ireland is answered by Mr. Meldon in the affirmative, chiefly on the grounds of the inadequacy of any other explanation, and, also, because it appears that cancer is the only disease which is causing a gradually increasing mortality all the world over. It has been urged that, of late years, as a result of better sanitation and other causes, the mortality from diseases other than cancer has decreased, and that many of those who now die of cancer would formerly have died of other diseases before they reached the age at which they were likely to develop cancer. It is also urged that, as our methods of diagnosis are gradually becoming more and more accurate, so deaths are more and more frequently registered under their true causes, it must, however, be remembered that accuracy of diagnosis is more likely to diminish the number of cases registered as cancer than to increase them. We must also bear in mind the increased number of cures which the more radical methods of modern surgery have undoubtedly produced. If, however, the prevalence of the disease is actually on the increase, we should expect that this increase would not only be noticed in the typical age period, but also in the other age periods in which cancer is not so common. The question whether cancer is increasing is intimately associated with another—Is the disease infectious or not? In spite, however, of the vast amount of work done on the subject, and of the very positive and dogmatic assertions made by some pathologists, the verdict still is that the parasitic origin of cancer is not proven. It will be remembered that, many years before the *contagium vivum* of tuberculosis was identified, its infectious nature was asserted, and we might almost say demonstrated, so that even had the tubercle bacillus not been discovered prophylactic measures against the disease might have been adopted. So also in the case of cancer; if it can be shown to be infectious, much may be done to stay its ravages, even though its true cause remains a mystery. The map presented by the Registrar-General in his report shows in a graphic way the striking partiality of the disease for certain counties in Ireland. Thus, in Kerry, the death-rate is only 2.76 per 10,000, while in Armagh it reaches 10.09, and, generally, the rate is higher in the Eastern than in the Western

counties. It would be interesting to compare the zymotic death-rate of these districts, for were it the reverse of the cancer rate it would go far to support the objection advanced above. It should be remembered that, at present, the two great varieties of malignant tumours, sarcoma and carcinoma, are to a great extent confused together, and, indeed, are often quite indistinguishable, save by careful histological investigation, consequently it is impossible to say definitely to which of the two the increased death-rate is due. Whether, then, this increased death-rate from cancer is merely an apparent one, or due to an actual increase in the prevalence of the disease, must, we fear, for the present, like the question of its parasitic origin, be regarded as undecided.

### THE PLAGUE.

ONCE again the plague is with us, coming, as of old, by trade routes. It formerly entered Europe by Byzantium and Venice, and for the short time that Spain encouraged commerce found an entrance through Cadiz. To-day the infected cities are Naples, Marseilles; and Glasgow. It is an occasion for thankfulness that of British cities the one in which the plague makes its entrance is the one best adapted for successfully dealing with it—a city in which sanitation is studied as a science and its laws administered with impartiality. As a disease the plague is very familiar to us; for ages we have known its natural history, and from time to time the British Isles have been decimated by epidemics of the "black death," as it was called in the past. All our knowledge of the disease may be summed up in the statement: it is a dirt disease, begotten of dirt, fostered by dirt, conveyed by dirt, and destroyed by cleanliness. As a rule it takes its rise in some overcrowded Chinese city, and is conveyed to Europe either by the overland route through Russia, the absence of personal cleanliness of the Russian peasant favouring its propagation; or by sea, where the unsanitary housing of the crews furnishes a suitable soil for its propagation. In the Middle Ages its march was slow, and during the winter months it seemed to halt at the frontiers of the different Western kingdoms and during its rest to acquire intensified virulence; and with the coming spring it entered new territories, and its course was ever marked by multitudes of victims. Winter had stayed commercial intercourse between the Orient and the Occident and the disease was not carried on until commerce once more brought Eastern spices to Europe. To-day steam has enabled business to continue uninterruptedly throughout the four seasons, and brought the Far East within a few weeks' journey. With this quickened transit the plague travels all the faster, hence we find that almost simultaneously Naples, Marseilles, and Glasgow notify the presence of the plague. The progress of medicine has latterly been so much belated that the lay public have come to expect of the science miraculous gifts. They quite ignore the fact that as science progresses miraculous gifts fall more and more into disrepute. Medi-

cine is expected to meet the possessed man at the gate and by an exorcism drive the evil spirit out. But medicine plays no such *role*; she instructs the people in the prophylaxis and treatment of the disease, and if the teaching is unheeded the foolish ones suffer unpitied. It is now nearly three hundred and fifty years since George Baker taught, as Senor Rubio teaches to-day, that soap and water are the best prophylactics, that they are to be freely used on the house, the dress, and the person. In case of infection wash the patient and burn the infected garments; keep the surroundings scrupulously clean and give nourishment. To this the most recent and the most authoritative writer, Montenegro, adds nothing. For the public the great truth is that cleanliness is a perfect protection against plague. As shown in the outbreak in Bombay, dirty surroundings will generate it and perpetuate it. As a prophylactic of disease we may accept John Wesley's dictum—"Cleanliness is next to godliness."

### Notes on Current Topics.

#### Mumps in Dogs.

MAN is not the only animal that is liable to that very painful disease, mumps. It also attacks, though rarely, the canine race. The literature of the subject is scanty, and until quite recently was confined to the cases observed by Schüssele in 1842 and by Hertwig. In these cases the origin of the malady was unknown, but in 1896, and again in 1897, Whittaker and Busquet showed two cases before the Paris Academy of Medicine, in which the disease appeared to have been transmitted to the dogs by human beings. On the second occasion evidence which tends to demonstrate the rarity of the affection in dogs was adduced by MM. Leblanc, Nocard, and Megnin, all eminent Perisian veterinary surgeons, and none of whom have ever seen similar cases. More recently, in *La Presse Médicale*, MM. Busquet and Boudeaud stated that they have satisfied themselves that the dog is capable of catching mumps, that the disease is transmissible from one dog to another, and that there is to be found in the salivary secretions of dogs suffering from mumps a special micrococcus. These observations of MM. Busquet and Boudeaud are interesting, for there remains much to be studied in the connection between the diseases of animals and those of man. Their first case occurring in a dog coincided with cases of mumps in human beings in the more or less immediate neighbourhood. The second was in a young animal, and the disease was manifestly due to contagion from the first case, for it was by playing with the plugs of cotton wool used to swab the buccal mucous membrane of the first animal that the second caught the disease. Three days after being thus exposed to the infection it began to sneeze frequently and developed a hoarse cough. The following day a swelling appeared in the right parotid region about the size of an orange. In both dogs the clinical evolutions of the

disease were similar. In the early days there was dulness and fatigue, with loss of appetite, frequent shivering, nasal obstruction, and continual sneezing. A cough was speedily developed, and at the same time the parotid swelling made its appearance. The skin over the gland became œdematous and slightly tender, and there was evident pain on mastication.

#### Comparative Medicine.

WE have long held the opinion that there is a great future before the comparative study of the diseases of animals and man. At present the veterinary department is kept too much apart from the study of human disease. It is true that the class of men who enter for the two professions are widely different, and as a rule the intellectual development of the average veterinary surgeon is not as high as that of the average doctor. The veterinary surgeon is not usually endowed with a scientific trend of thought; there are, of course, exceptions, but they are few and far between. The majority do not take that interest in their profession that one might expect, a fact that is probably largely due to the debasing influence of the persons with whom they are brought daily into contact, for it is well known that the respectability of the people who have much to do with horses is in inverse proportion to the nobility of the animal with which they have to deal. We believe, however, that there is a better future for the veterinary profession, a future which will largely owe its improvement to the comparative study of the diseases of man and animals. This is a study which has been too long neglected, but is becoming an absolute necessity in the face of modern sanitary science.

#### The Light Treatment of Lupus.

THE light treatment of lupus, introduced by Professor Finsen, of Copenhagen, has, so far, been attended by satisfactory results. Several installations have been fitted up in London and through England, and the accounts which we hear are such as to justify further installations. It is yet too soon to express a final opinion as to the actual value of this mode of treatment, but it may safely be said that it has proved its right to a full trial. In Ireland, so far, no installation has been started, and consequently we are glad to learn that in the near future this will not be so. At the annual meeting of the friends and supporters of the City Hospital for Diseases of the Skin, which was held last week, Dr. C. M. O'Brien, honorary physician to the hospital, announced that it had been determined to start a "lupus lamp." Unfortunately, as the funds of this hospital are not in quite the condition that its friends and supporters would wish them to be, the will cannot be immediately equivalent to the deed. However, the delay will not be long. To provide the necessary money to purchase what is always an expensive installation, it has been decided to start a special fund. We trust that the request of the hospital authorities for contributions will be speedily answered. The City Skin Hospital is not, however, to be allowed to have a

monopoly of "lupus lamps." The Royal City of Dublin Hospital is, thanks to the generosity of Mr. Marcus Moses, one of its governors, also to be equipped with one. Mr. Moses has expressed his intention of presenting the hospital with the latest modification of the Finsen lamp, a modification which is said to render it possible to obtain in fifteen minutes the same result which the original Finsen lamp required an hour to effect.

#### The General Medical Council Election.

WE have received the text of Dr. Charles W. Hayward's address as candidate for the Council, for which we are unfortunately unable to find space. His views appear to be generally in accord with those of Mr. Victor Horsley and Mr. George Brown; that is to say, he condemns the election of corporate representatives by the governing "ring," in lieu of by the general body of licentiates and diplomates, and he is strongly in favour of financial reform, though, as he does not go into details, this may mean anything or nothing. We agree with him that it is absurd that the Council should be put to the expense of a separate election when Mr. Horsley's period expires, especially when we find that the single election costs as much as the general election. The fault, however, does not lie with the Council, but with the faulty wording of the Medical Act. Dr. Hayward is apparently in favour of the registration of midwives "when they have had whatever training is deemed sufficient to entitle them to registration," another delightfully vague pronouncement which does not commit the candidate to very much. He is an advocate of the "one portal" system, though this is hardly within the sphere of practical politics at present. Incidentally he is in favour of the reform of the government of the Royal Colleges, but this is hardly a Council question. With regard to the Medical Aid system he would welcome what he calls "comfortable protection," but he does not indicate how he hopes this may be obtained. Until we know for certain what is the candidate's attitude towards homœopathy we deem it our duty to regard him with suspicion, moreover, the unnecessarily energetic language in which he couches his address leaves the impression that his presence on the Council would not have for effect to expedite the realisation of the reforms which he is willing to advocate.

#### The Working of the Inebriates Act.

THE report recently issued to the Home Office by Dr. Walsh Braithwaites leaves no room for doubt as to the success of the Inebriates Act of 1898. Two facts are rendered clear—that the accommodation at present available is far less than is required, and that there is still much reluctance on the part of the magistrates to put the measure into full force, partly from its novelty, partly from mistaken kindness. Both these reasons only require time for their remedy, and we are, therefore, justified in believing that so salutary an Act as this will soon be applied to the full extent of the powers it confers, and in

hoping that Parliament will one day go much further. We are just beginning to realise that what we now consider as vices are in reality more of the nature of disease, and with that realisation comes the dawn of better things in the treatment of crime and its cousins—the various vicious habits. The craving for alcohol is as well defined a disease as scarlet fever or small-pox. Treated early, and with firmness and wisdom, there is every hope that the victim of such craving may be restored to normality with every trace of his depraved appetite gone. At present the alcoholic is treated with too much mistaken kindness, he is allowed to pursue his own course, to ruin his own career and that of his family until it is too late for him to be reclaimed. Some magistrates appear to be possessed by the mistaken apprehension that when the Act is invoked the applicants may have sinister motives, but, as an able writer on the subject has pointed out, the times when the exercise of such powers as the Act gives would be used to further evil ends are passed, and in these days of aggravated publicity the probability of abuses is small. At present, judging from the report alluded to, we are dealing merely with the fringe of a large evil. There are now existing only twenty-two institutions for dealing with inebriates, and there is room for several times as many. There is plenty of scope for well-conducted private homes, and for charitable institutions for the poor, a class in which the working of the Act is potent for incalculable good. So far the results of the measure are very encouraging, and it is to be earnestly hoped that, having once started in such a work, the legislature will go still further, and help to so stay the liberty of the habitual drunkard that the bestial exhibitions of chronic alcoholics may become more and more rare.

#### Vaccination and Small-pox.

AT a meeting of the Executive Committee of the Jenner Society, recently held at Gloucester, it was resolved unanimously, that it is desirable in the interests of the public health as well as for the fuller appreciation of the truth concerning vaccination, that in every outbreak of small-pox the authority responsible for the isolation of infected persons should, at as early a date as possible, and from time to time during the outbreak, issue, for the information and assurance of the public, returns of all cases of small-pox under their observation, in a form showing the vaccinal condition of all persons attacked who are alleged to have been vaccinated, in regard to (1) their ages; (2) the time when vaccination was done; (3) the evidence, so far as may be discoverable, from scars or other sources, of the character of their vaccination; (4) the type of the attack; and (5) its result (so soon as this can be done). We cordially concur in this expression of opinion. It is highly desirable that such returns should be laid before the public promptly, frankly, and completely. The present tactics of the anti-vaccinationists are to confuse the public by adducing apparent contradictions in the statistics, a trick which is easily performed by

taking special groups of figures and according to them the value of the aggregates from which they are drawn.

### The State Supply of Vaccine.

It is certainly a remarkable and not altogether creditable circumstance that private practitioners should be unable to secure a supply of lymph from Government laboratories. As matters stand private practitioners are dependent for their supply almost exclusively on foreign sources, French, German, and Swiss. Under the old system of arm-to-arm vaccination the practitioner might be expected to maintain his own supply, but this is obviously not possible in respect of calf lymph, and one would have thought that the first duty of the Government was to undertake the provision of the material. Under proper management the Government institutions might easily be made self-supporting, indeed they might even prove a source of considerable profit, for it is obvious that if the preparation of vaccine were not a profitable undertaking there would not be so much private competition. Representations ought certainly to be made to the Government urging this view, but the only means of bringing pressure to bear would seem to be through the press.

### Deaths under Chloroform.

THE heading "Deaths under Chloroform" is a too familiar one to readers of both medical and lay journals. Too familiar, too, is the insufficiency of evidence as to the direct cause of death and the treatment adopted. In ninety-nine out of every hundred cases, we meet with the same paucity of detail and the usual generalities—"everything was done that could be done," and so forth. For many reasons, it is most desirable to give the procedure adopted to revive the patient, to say how much chloroform was used, to describe the apparatus employed, to note the length of time the patient was under the anæsthetic, and to detail the results of post-mortem examination. Not so long ago the stereotyped conclusion in such cases was "heart failure," or "fatty degeneration of the heart." Within the year, we have known of such a return, when the post-mortem revealed a normal condition of the heart. The truth is, we shall never come to a proper knowledge of how to use this powerful anæsthetic, chloroform, until the coroner's inquest is made a searching one, and all the details of the administration of the drug, and the measures taken for the safety of the patient, are fully set forth. Should a death occur from the administration of opium or strychnine, it is considered necessary to tell how much of the drug was given, when it was given, and the mixture in which it was administered. Why should these particulars not be given in a case of chloroform poisoning? The knowledge that every detail of the administration must be given at an inquest, would necessitate the keeping of a careful record of each administration, a much to be desired rule. Chloroform may or may not be the lethal drug it is said to be. The lethal

result may be inherent in the agent, or simply due to carelessness. A searching inquiry into the cause of every death would be a step towards eliminating carelessness. We purposely avoid the consideration of such questions as how chloroform should be given, or the best means of resuscitating an asphyxiated patient. We do no more than urge a searching inquiry into the cause of every death under chloroform, in the hope that by so doing the importance of the duty may be impressed.

### Bone-setters.

THE question of the status of the "bone-setter" has been raised by a remarkable controversy lately conducted in the columns of a sporting contemporary. The matter began by a certain Atkinson, a notorious bone-setter, being requested to give his services to the crippled children of the Potteries Cripples Guild, a charitable institution recently started. The local medical practitioners, who had previously offered their services to the institution, naturally withdrew in a body, on the ground that Mr. Atkinson was not a qualified medical man. Availing himself of the hospitality of our sporting contemporary, the bone-setter had the impudence to suggest his being allowed to demonstrate his superior knowledge of bone-setting before a committee of the medical profession. It is hardly necessary to point out that such a challenge could be made with perfect safety, since no medical man of standing would consent to act on such a committee, a fact of which the astute bone-setter was probably well aware, though he thought it worth while to avail himself of this opportunity of advertising himself. It is strange to see this well-worn subject revived, for it was settled so long ago as 1867 by Sir James Paget in an article in the *British Medical Journal*. Sir James pointed out that many cases of old sprains and stiffened joints after injury were often benefited by the forcible wrenching practised by bone-setters. He also mentioned the fact that the patients who are cured by these men boast of their wisdom in acting against the advice of their medical man, but those who are damaged are ashamed and hold their tongues. Obviously all the methods used by bone-setters are well known to every competent surgeon. They may, in some instances, do good where a timid surgeon fails, but the damage they cause in the aggregate is probably considerable.

### Fires in Oil Shops.

THE frequent recurrence of disastrous fires in oil shops, but too often accompanied by loss of life, is a matter which might usefully engage the attention of municipal authorities. These shops, which almost invariably form part of ill-constructed buildings, the ready prey of fire, are filled with the most inflammable material, in fact, a chance spark is all that is required to set the structure in a blaze. The remainder of the house is often let out in single room tenements into which whole families are crowded and escape becomes impossible owing to

the absence of any structural provision for this not unlikely catastrophe. Last week a fire broke out in an oil shop near Euston Road, at 2 o'clock in the afternoon. The residents in the upper part of the building received prompt warning, in spite of which three of them perished miserably in a few minutes, before assistance could be rendered, although this was near at hand and was promptly available. It is not too much to ask that special regulations should be drafted to prevent a repetition of such terrible disasters. No building should be employed for the purpose of an oil shop until it has been certified as suitable by the Council's surveyor, who would, as a matter of course, insist on a fireproof floor between the shop and the upper part of the building. It is open to question indeed whether, under the circumstances, it should be allowed to convert such buildings into tenement houses at all. We trust that no time will be lost in attending to this matter.

#### The Retirement of Dr. Glover.

WE receive with much regret the intimation that considerations of health prevent Dr. Glover presenting himself for re-election on the General Medical Council. During the fifteen years of Dr. Glover's tenure of office he has consistently and temperately advocated the interests of the profession, and more particularly of the general practitioner before the Council. Thanks to his conciliatory attitude he retained throughout the goodwill of his fellow members, even such as were constitutionally opposed to the views which he sought to impress upon the Council. Dr. Glover was not in the habit of making speeches *à effet*, but confined himself to measures of reform which appeared to him to be attainable. This led to his being reproached with lukewarmness, but those who had opportunities of observing his management of affairs are fully aware that he lost no opportunity of furthering the interests of his constituents. His assistance in committee work was always greatly appreciated, and we can quite understand that this, in addition to the strain of a large general practice to which, of late, the fatigue of electioneering was superadded, proved too much. It is satisfactory to note that this step has been taken not in deference to any actual ill-health but on medical advice; in fact, it is prophylactic rather than curative. We part company with Dr. Glover with regret, and we trust his successor will cultivate his amenity of manner without on that account sacrificing the interests confided to his charge.

#### The Effects of Lead upon Lead Workers.

So many ill effects have been, from time to time, attributed to working in lead, that it is of interest to note the opinions of anyone whose personal experience has enabled him to state facts which tend to show that the evil has been somewhat exaggerated. Dr. F. Shufflebotham has contributed to a contemporary the results of a systematic examination of the workmen employed in lead processes in thirteen

of the Staffordshire potteries. In these factories between 6,000 and 7,000 persons are employed, and, of these, 528 are engaged in lead processes—348 men and 179 women; 255 men and 44 women had worked in lead for periods varying from five to more than thirty years. Dr. Shufflebotham examined all the lead workers with special reference to the symptoms which are usually associated with lead poisoning. He further obtained the history of the pregnancies of the wives of 188 men who were married. His conclusions are so opposed to the popular notion of the effects of lead poisoning that they are worthy of being recorded. It must, however, be remembered that Dr. Shufflebotham draws a distinct line between cases of lead poisoning and cases in which there is only evidence of the presence of lead in the system. Among 527 cases of lead workers there was only one case of lead poisoning. Individual symptoms, which at first sight might have been attributed to lead poisoning were found on closer examination to be due to other causes. The health record of the lead workers was excellent, and would compare favourably with that of a like number of workers in any averagely healthy trade. Ninety-one operatives, who had worked in lead for more than twenty years, were not suffering from any ill effects, although they had worked for years under practically no regulations. In conclusion, Dr. Shufflebotham states the very obvious but still often forgotten truism—"It must be remembered that lead workers are subject to the common ailments of life just in the same way as other people."

#### A Fatal Tattoo.

A LAD died a few days since at Newport (Mon.) as the result of pyæmia, consequent on his having been tattooed by a travelling showman. Although a catastrophe of this gravity is certainly very rare as the result of this silly practice, numerous instances are on record in which syphilis has thus been inoculated, the menstruum of the colouring matter frequently being the saliva of the operator. Under the circumstances, we are not sure that the practice does not constitute a criminal offence, and it is a matter for surprise and regret that the coroner's jury did not append a rider to their verdict condemning it.

#### Untrustworthy Serum.

AN outbreak of tetanus in children following injections of diphtheria antitoxin is reported from St. Louis, U.S.A., resulting in eleven deaths. This lamentable occurrence, which will certainly be closely investigated, is on a par with that reported not long since from Italy. Obviously the presence of the tetanus poison in the serum may have been due to careless manipulation in the laboratory, not a very probable thing, or to the employment for the preparation of the serum of an animal suffering from the disease in an unrecognisable, or, at any rate, an unrecognised form. The first contingency would be rendered impossible by dealing with diphtheria serum only in laboratories exclusively devoted to its preparation, and it will be for bacteriologists to intro-



duce a method of detecting incipient tetanus in the animals employed in order to obviate this terrible risk. A simple plan, which ought never to be omitted, would be to test the action of each batch of serum before issuing it to the public. A few more catastrophes of this magnitude would go far to inspire grave doubt in the public mind as to the trustworthiness of bacteriological methods.

#### The Penalty of Wilful Negligence.

THE Metropolitan Asylums Board have the legal power to recover the cost of maintenance of patients suffering from infectious disease treated in their hospitals, but for some reason this right has never been enforced. There may be valid reasons why this should be so, but, as was pointed out by Dr. Gubb in a letter published in *The Times* last week, no such indulgence ought to be extended to persons who, or whose children, contract small-pox in consequence of their wilfully or "conscientiously" omitting to avail themselves of the protection afforded by vaccination. If the Board would cause proceedings to be taken to recover the expense of maintenance in all cases of unvaccinated small-pox patients it would be brought home to a certain class of the population that "conscientiousness" confers responsibilities as well as immunities.

#### The Surgery of the Large Intestine.

THE operative treatment of stricture of the large intestine is one of the most remarkable features in abdominal surgery. Though the diagnosis of this condition is frequently made with comparative ease when the case is presented to the surgeon's notice, it is often far from easy in the early stages. It must probably ever remain impossible to diagnose stricture of the intestine as early as could be wished, since temporary and fallacious improvement so frequently takes place when the patient comes under the regimen of careful dieting and medicinal treatment. An excellent article by Mr. F. M. Caird has lately appeared in a contemporary. (a) on "Operative Interference in Cases of Stricture of the Large Intestine." Twenty cases are described on which the author has operated, and his record is one of which he may well be proud. As it is obviously impossible to give in detail the clinical history of each case—when the number is so large—in the space available in a journal, it is to be hoped that Mr. Caird will embody his experience, and the judgments he has formed from it, in a more pretentious form. The paper is concluded by some eminently practical remarks. It is pointed out that "carcinoma of the sigmoid readily gives rise to obstruction, and this may occur suddenly without any marked antecedent symptoms. In such cases the sensitive distended cæcum may simulate the site of stricture." This is an observation of importance. The fact that the transverse colon has been found contracted while the cæcum was distended, has led to the conclusion during operation that the

constriction was higher up than was really the case, with the result that a "ring" stricture of the sigmoid has been overlooked. The apparent passage of the long rectal tube beyond the limits of the rectum before operation was undertaken lent colour to the opinion at the operation that the stricture was higher up the bowel. Mr. Caird, in our opinion, very correctly places a high value on the use of enemata for diagnostic purposes. Needless to say they are best given either by the surgeon himself or by some one under his direction and in his presence.

#### A Knighthood for Mr. George Anderson Critchett.

WE hasten to offer our congratulations to Sir George Anderson Critchett, F.R.C.S.Ed., Surgeon-Oculist to His Majesty, and Senior Ophthalmic Surgeon to St. Mary's Hospital, on his selection for the honour of knighthood. Indeed, it is not without a feeling of surprise that his inclusion among the recipients of "birthday honours" reveals to us the fact that it still remained for him to be knighted. Mr. Critchett's pre-eminent position among ophthalmic surgeons in the metropolis, and his long record of surgical work, keeping aflame the torch handed on to him by his eminent father, constitute a legitimate claim to titular distinction; and the recognition of this fact by those in power awakens a feeling of satisfaction, which, we doubt not, will be generally echoed in medical circles.

#### Small-pox in London.

THE steady extension of the outbreak of small-pox in the metropolis cannot fail to excite the gravest apprehensions on the part of all who are acquainted with the natural laws that govern the spread of that highly infectious malady. The very size of London constitutes one of the most serious elements of the situation. It means that a great number of unprotected individuals are brought into daily contact with one of the most communicable of all the infectious diseases. Moreover, owing to the anti-vaccinationist tendencies and tactics of many of the boards of guardians, the unprotected cases are in many instances congregated in particular districts. When small-pox once gets a foothold in an unprotected community, its progress is likely to be marked by devastation such as that recorded by history in some of the islands of the Pacific, where the disease found virgin soil wherein to propagate. Fortunately, in spite of the thickheadedness of anti-vaccinationist guardians and of the foolish backsliding of Mr. Balfour's permissive vaccination Act, the evil will always be checked by the presence of a fair percentage of sane persons protected by vaccination here at home in the United Kingdom. For all that, the returns of the present outbreak in London are of a most disquieting character. The progress hitherto has been steadily in an upward direction, so that at the end of last week there were no less than 309 cases under treatment in the various metropolitan fever hospitals. The gravity of the situation may be to some extent gauged when we attempt to realise the mean-

(a) *The Scottish Medical and Surgical Journal*, September.

ing of so large a number of centres of infection scattered among the dense population of the metropolitan area.

#### Human and Bovine Tuberculosis.

THIS subject was discussed at a meeting of the Council of the Central and Associated Chambers of Agriculture on November 5th, and the report was adopted that no change in legislation concerning the slaughter of tuberculous cattle should be made till the result of the Royal Commission was known. This question is one of great importance, owing to the recent remarkable statements of Professor Koch, who, it will be remembered, declared that tuberculous infection in man rarely, if ever, arises from the milk and meat of tuberculous cattle. The opinion of such an authority must naturally be received with attention, but in view of the importance of the matter to the public health it is certainly wise to defer any change in the strictness of legislation till a Royal Commission has made its report.

A PROPOSAL has been brought forward to offer a small remuneration to the junior medical staff of the Birmingham General Hospital; but in view of the present unsatisfactory financial position of the institution, this suggestion has met with opposition. It really seems hardly fair to ask duly qualified men to discharge the onerous and responsible duties appertaining to these posts without covering their out-of-pocket expenses, and certainly an annual stipend of £50, the sum suggested, does not err on the side of extravagance.

A DISCUSSION on the various aspects of small-pox and vaccination is announced to take place at the Hunterian Society to-day (Wednesday) at 8.30 p.m. Dr. MacCombie and Dr. Major Greenwood will contribute papers bearing on the subject, the former on "The Present Position of Small-pox and Vaccination," and the latter on "The Diagnosis of Small-pox, with Remarks on Prodromal Rashes." Dr. W. A. Bond has promised to take part in the discussion.

THE Autumn Session of the General Medical Council will be opened on Tuesday, 26th inst., at 2 p.m., when important business will be considered.

#### PERSONAL.

DR. HENRY DUTCH has been elected representative of the Grosvenor Ward on the Council of the City of Westminster.

DR. CANT, of Coleshill, has been appointed medical officer to the Marston Green Homes, Birmingham, having been selected from among three candidates.

SIR WM. DALBY will preside at the second annual dinner of the Otological Society, which is to take place on Monday, December 2nd, at the Café Monico.

PROFESSOR WATSON CHEYNE delivered an address on "The Treatment of Wounds in War" at the opening meeting of the Midland Medical Society at Birmingham on Thursday last.

DR. THOS. R. FRASER, F.R.C.S., Professor of Materia Medica and Clinical Medicine in the University of

Edinburgh, has been elected President of the Edinburgh Medico-Chirurgical Society.

SIR WILLIAM BROADBENT presided at the Royal United Service Institution yesterday, when Dr. Leigh Canney gave a lecture on "Typhoid, the Destroyer of Armies, and its Abolition."

THE M.D. degree with honours was bestowed on Mr. David L. Cairns, M.B., at the Graduation Ceremony of the Glasgow University last week. No other candidate obtained honours, but several were "highly commended."

DR. FRANK OGSTON, of Dunedin, New Zealand, has been appointed medical officer of health for the southern half of the South Island. Dr. Ogston is also Lecturer on Medical Jurisprudence and Public Health in the University of Otago.

WE hear that Mr. Mayo Robson, of Leeds, has acquired No. 8, Park Crescent, Portland Place, as a London residence. He will, however, continue to occupy the position of Emeritus Professor of Surgery in the Yorkshire College, and of Senior Surgeon to the Leeds Infirmary in connection with his practice in Leeds, dividing his time between the two cities.

SURGEON-GENERAL T. F. O'DWYER, A.M.S., who is vacating his appointment as Principal Medical Officer at Aldershot, was entertained at a luncheon last week at the Royal Hotel, when the Chairman of the District Council bore testimony to the splendid service he had rendered, and assured him that he would leave Aldershot to the regret of the whole community.

It does not frequently happen that medical men become Masters of the ancient City Corporations. We are glad, therefore, to record that on Wednesday last Dr. George Flux and Sir Edward Montague Nelson, K.C.M.G., took their seats as Prime Warden and Renter Warden respectively of the Worshipful Company of Dyers, they having been previously elected at the last General Court.

As will be seen in another column, Dr. Glover has withdrawn his candidature for the Medical Council on health grounds. There is no further addition to the list of names, but we are informed that a large Committee has been appointed to promote the candidature of Dr. Norman Walker for Scotland, of which Dr. A. Gibson is chairman, and Dr. F. D. Boyd and Dr. E. J. A. Berry are secretaries.

#### BIRTHDAY HONOURS.

KNIGHTHOOD on George Anderson Critchett, Esq., M.A. Cantab., F.R.C.S. Ed.

C.M.G.

William Robert Henderson, Esq., M.D., Principal Medical Officer of the Gold Coast.

Lieut.-Colonel George Hart Desmond Gimlette, M.D., Indian Medical Service.

Honorary Major Thomas Henry Hill, lately Senior Assistant Surgeon, Indian Subordinate Medical Department.

INDIA OFFICE, Nov. 9, 1901.

KAISAR-I-HIND MEDAL FOR PUBLIC SERVICE IN INDIA.

The King has been pleased to approve of the grant of the Gold Medal to the following:—

Major Herbert Edward Deane, B.A.M.C.

Major Thomas Edward Dycen, M.B., C.M., Indian Medical Service.

Lieut.-Colonel James McCloghry, F.R.C.S., Indian Medical Service.  
 Captain Edmund Wilkinson, F.R.C.S., Indian Medical Service.

## Scotland.

[FROM OUR OWN CORRESPONDENTS]

**THE NEW GARTNAVEL APPOINTMENT.**—Dr. Oswald, Medical Superintendent of the Glasgow District Asylum, Gartloch, has been appointed Physician Superintendent at the Glasgow Royal Asylum, in room of Dr. Yellowlees, retired. The salary is, of course, considerably reduced, because Dr. Yellowlees is a man of great reputation and experience, and Dr. Oswald is a young man. The Board has been feeling for a long time that the salary of £2,000 was much too large, even apart from age altogether, inasmuch as a consultation practice goes along with it. On this point, however, we will not grumble, for, being medical men, we feel bound to support our profession, though we feel that the position is a sufficiently remunerative one. Dr. Oswald is a man who will do it justice, and he has worked very hard. He has already made his name, and will get due distinction for the name of lunacy administration in Scotland.

**PLAGUE IN GLASGOW.**—It is gratifying to be able to report that the plague, if not stamped out, at least shows no sign of spreading in Glasgow. No fresh cases have been reported, and the four patients at present in the Fever Hospital are progressing satisfactorily. It is stated that the rats destroyed in the Central Hotel have been proved to be infected, and while this state of matters remains there is, of course, always the fear of recrudescence.

**DEATH OF TWO PROMINENT SCOTCH PRACTITIONERS.**—Two of the best-known Scotch provincial practitioners have been taken from our midst during the past week. The death of Dr. Connel, of Peebles, was announced on November 4th, and only a day or two later that of Dr. McKelvie, of Oban. Dr. Connel was a well-known figure in Edinburgh medical circles, and both there and in his own country he will be missed by all who knew him. He took an active interest in things medical, and was at one time President of the local branch of the British Medical Association, of the Edinburgh Obstetrical Society, and of the Harveian Society. Few men were more respected than he, and his name was a household word over the whole eastern border. Dr. McKelvie was one of the most prominent medical men in the West Highlands, and his name will always be associated with the isolation hospital which he gave to Oban. It is said that he was instigated to this act of generosity by being called to attend a wealthy American tourist, residing at one of the Oban hotels, when, finding that his patient was suffering from an infectious disease, he was compelled, *faute de mieux*, to isolate him in the poorhouse. With characteristic energy he at once set to work to remedy this anomalous state of matters, and the present isolation hospital is an evidence of his success. Though he had failed in health lately, his death came as a surprise, as he was doing his usual work only two days previously.

**GLASGOW OPHTHALMIC INSTITUTION.**—A course of post-graduate lectures on Diseases and Injuries of the Eye was inaugurated on Tuesday last, under the presidency of Professor John Glaister. There was a numerous attendance of general practitioners. In addition to a presentation of clinical cases and a display of stereoscopic photographs, Dr. Maitland Ramsay gave a lantern demonstration on Conjunctivitis, special reference being made to the microbic origin of its various forms and their treatment.

### New Munificent Donation to London Hospitals.

The estate of the late Mr. Matthew Whiting, of Auckland, Wandsworth Common, has been valued at £153 104 8s. gross, including personalty of the net value of £140,870 18s. 7d. After disposing of about £20,000 to relatives, Mr. Whiting left the residue of his property, in trust in equal shares, for twelve London hospitals.

## ELECTION OF DIRECT REPRESENTATIVES TO THE GENERAL MEDICAL COUNCIL.

**FELLOW PRACTITIONERS OF ENGLAND AND WALES.**—You are perhaps aware from announcements in the medical journals that I have been forbidden, at what seems a most inopportune moment, by my medical advisers, to take part in public meetings. They do not go so far as to advise me to abandon my candidature, but they counsel some diminution of work. I am in the enjoyment of my usual health, and my eye is almost itself again. Still, I am bound to respect advice given me by my truest friends, whose names would command the respect of the profession.

The relinquishment of practice would be distasteful to me, and altogether beyond the necessities of the case. The only other way in which I can relieve myself of work is by retiring from my candidature for the honourable office of representing you in the General Medical Council. I can do so now without putting the Council to the inconvenience and expense of a separate election.

These circumstances determine me to withdraw from the present contest. I cannot tell you with what reluctance I do so, especially at a moment when questions of great interest to the public and the profession are before the Council in which I have, as I believe, taken a part representing the general judgment of my fellow practitioners—nor can I say how grateful I feel to the profession for its kindness and confidence during the last fifteen years, and of the continuance of which I have ample testimony on the present occasion. I ask you to accept my best thanks.

The office of a Direct Representative in the General Medical Council, with a constituency of over 23,000, is not an easy one. Many questions present themselves at the Council Board in a very different light from that in which they appear when viewed from a purely professional standpoint. And the Direct Representative has to act accordingly. I ask you to believe that on all such questions I have tried to remember the interests of the profession, as well as those of the public and to harmonise the two.

I have endeavoured to advance medical education, to maintain the standards of professional conduct, and to keep the *Regi ter* pure. That I have erred often goes without saying, but I am sure you will be more blind than critical towards my faults, and will give me credit for having tried to maintain the cause of Direct Representation in the General Medical Council, which, after all, even its critics must admit, is the great Council of the profession.

With deepest thanks, I am, Fellow Practitioners,

Your obedient servant,

JAMES GREGG GLOVER.

25 Highbury Place, N.

### CANDIDATURE OF MR. GEORGE BROWN AND MR. GEORGE JACKSON.

#### MANCHESTER AND DISTRICT COMMITTEE.

At a meeting of practitioners held on Friday afternoon, November 8th, at the Deansgate Hotel, Dr. John Watson, of Ardwick, in the chair, it was resolved to form a committee to take steps to secure the election of Mr. George Brown and Mr. George Jackson as direct representatives of the profession on the General Council of Medical Education and Registration.

Only a few hours' notice of the meeting had been given, consequently but a small number of the fifty invited were present. Several replies were received expressing a desire of the authors to be placed on the committee, and already twenty-nine representative general practitioners have personally promised to serve, and many others have pledged their votes to these two candidates.

The following officials were appointed:—Chairman: Jas. Brasseley Brierley. Treasurer: G. H. Broadbent, M.E.C.S., L.R.C.P.I. and L.M. Hon. Sec.: J. Percival Brown, M.B., Ch.B., Vic.

**ERRATUM.**—In the first line of Dr. Brierley's postscript to his letter on the above subject in our issue of last week the word "refuse" should read "return."

## Correspondence.

[We do not hold ourselves responsible for the opinions of our correspondents.]

### DEGREES FOR LONDON STUDENTS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In your last issue there appeared an interesting leading article under the above heading in which you refer to the aims and objects of the "London Licentiate's and Members' Society."

There is little doubt that opposition will be forthcoming if the Royal Colleges obtain powers to grant degrees. I submit that such opposition is not just, and therefore should have no weight.

Why should not London, with its 4,546,752 (in 1899) inhabitants, equaling the whole population of Scotland, have two bodies granting medical degrees when that small division has no less than four? The old University of London would continue to grant a degree of an honors standard, and the Royal Colleges a pass degree in medicine.

Why should not the above-named bodies combine to perform these respective functions in conjunction with one another? Why is the suggestion that the Royal College of Physicians of London be requested to rescind its bye-law, &c., considered impracticable?

The Royal Colleges have as much right to give their diplomates the courtesy title of Dr, as any Provincial University has to concede this title to their Bachelors of Medicine outside the precincts of the University.

As to the suggestion respecting the holders of the F.R.C.S. and M.R.C.P.Eng., they already have a superior professional status, and require no enhancing in value. In fact, the Royal Colleges have seen the necessity of safeguarding the holders of these titles by reserving the great London Hospitals as their special preserve, forgetting the interests of their Licentiate's and Members, the latter not having the franchise of their Colleges.

I submit, therefore, to the consideration of the Royal Colleges, that if they are unable to adapt themselves to the times they can hardly expect men to enter for the conjoint diploma when, with the same amount of time and study, and the passing of similar examinations, they can obtain a provincial degree, with its many advantages, professional, social, and pecuniary.

I am, Sir, yours truly,  
F. W. COLLINGWOOD.

63, Wimpole Street, W.

### THE "ELUSIVE SECRET" OF CANCER CAUSATION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In your editorial note referring to the German Emperor and his steps to promote the study of "Cancer" you remark, "The secret of the causation of cancer is so elusive that, if mankind can ever hope to wrest it from the hand of Nature, it is only by means of a concentrated, sustained, and well-equipped attack." Will you permit me to record an emphatic protest against the opening words of this sentence? First, on the grounds that they are not altogether true in substance or in fact. Secondly, that they lend countenance to that regrettable feature in modern lay journalism which so often displays itself by sensational paragraphs anent "Cancer," assuming therein a mystery which does not exist, and attributing to the medical profession a practical impotence in its treatment which is enormously exaggerated.

I venture to submit that there is no secret or obscurity whatever about the gross causes of "cancer," using the word "causes" in its familiar acceptation, to denote immediate antecedents, or forces, operating to produce a definite result in an intelligible manner. If we pass further to teleology, we assuredly find mystery enough; but no more in the development of cancerous maladies than in any other morbid or even physiological process—than in the law of gravity.

No single instance of ordinary cancer ever appears with-

out such well-recognised and ascertainable antecedents. Take, for instance, the familiar mammary carcinoma of woman. We have here an organ which, after a period of development, followed by one of functional activity, passes into a third of devolution, of final degeneration and decadence. Any conditions gravely interfering with the natural slow and gradual course of the last stage result in gross disease. Cancer is only one of the necessary consequences of this perturbation. Cysts and other forms of benign tumour are generated in exactly the same way. But we invariably find that the antecedents have been operative in full force for a considerable period of time, and, excluding teleology, of course, we can have no difficulty in comprehending how the net result has accrued. The same with uterine cancer.

Take, again, Epithelioma, the prevalent "cancer" of the male. We find an unhealthy mucous membrane in an elderly man. Or, occasionally, in a younger one we see this structure depraved by chronic alcoholism or syphilis. A little crack casually occurs and refuses to heal. It is continually rubbed or chafed by some agency, which need not be specified. After a prolonged course of such treatment the ordinary phenomena of malignancy appear. Where is here the secret or mystery? The above is a very ordinary and familiar train of events. I have been accustomed in lectures to instance it as "an experiment in cancer-production performed every day by Nature before our eyes."

We do not certainly comprehend why the particular cells concerned, whether mammary or mucous, should change their natural behaviour, and should become the active agents of those grave phenomena summarised by the phrase "cancer process." The autostic theory purports to explain this transformation; but still that is no more than a theory awaiting experimental elucidation. Exactly the same could be said of the ultimate phenomena of any disease which could be named, or of the ordinary process of healthy growth.

It involves no end of fallacy to talk of "cancer" as though it were a single disease. In fact, one might as well talk of "fever." Every separate tissue has its own special form of malignancy, and the causes which operate upon each of those before its special malignant lesion is generated are exceedingly diverse and varied. For those who care to study the matter from a more scientific point of view than that of the average lay journalist, the group of diseases popularly known as "cancer" is a sufficiently large one. The first step towards scientific accuracy is a recognition of that fact, and particularly in discussing the causation, the inclusion of all the above under a single term is peculiarly misleading.

Meanwhile, with all due respect, I would urge on your consideration that the gross exciting causes of each and all these growths is perfectly well known, has been formulated over and over again, and can hardly be admitted as even within the sphere of legitimate controversy. While so much remains truly obscure, it is surely a great waste of force to keep on professing doubt about well-attested sequences. No reasonable man now cares to argue that the world is round.

I am, Sir, yours truly,

HERBERT SNOW.

Senior Acting-Surgeon,  
Cancer Hospital.

6, Gloucester Place,  
Portman Square, Nov. 7th, 1901.

## Obituary.

ALEXANDER HUGHES BENNETT, M.D., F.R.C.P.

We have to record the death of Dr. Alexander Hughes Bennett, at Ladbroke Grove, Notting Hill, on November 1st, at the age of 53. He was the only son of the late Professor John Hughes Bennett, who for many years held the chair of Institutes of Medicine in the University of Edinburgh. Alexander Bennett took his M.D. in that university in 1872, obtaining the gold medal for a thesis on the pharmacological actions of theine, caffeine and allied substances. After a short time passed in the service of the P. and O. Company, he came to London and was appointed Medical Registrar at the Westminster

Hospital in 1875, and two years later assistant physician. He early devoted himself to the study of diseases of the nervous system, and published a series of lectures on "Epilepsy," and various papers on "Spastic Paraplegia" and "Muscular Hypertonicity." Metalloscopy and Metallotherapy for a time engaged his attention, but the results failed to answer his expectations. For some years he was on the staff of the Hospital for Epilepsy and Paralysis, and the West End Hospital for Diseases of the Nervous System. The drudgery of out-patient work was but little suited to his temperament, and in 1893 he severed his connection with the Westminster Hospital. His knowledge of medicine was profound, but unlike his illustrious father, he had no special gift as a clinical teacher. For many years he suffered from a painful affection of the nervous system, which was supposed to be of the nature of tabes without ataxy, and for which he consulted most of the specialists both in London and on the Continent, but without deriving much benefit. The paroxysmal pains, which were the most prominent feature of his complaint, compelled him to relinquish active practice. He was a man of exceptional ability, who under more favourable circumstances would have been a successful physician. His last public appearance was in July last, when, at the opening of the Hughes-Bennett Laboratory of Experimental Physiology, given by his sister, Mrs. Cox, to the University of Edinburgh, he was in capital spirits, and made a most excellent speech. The immediate cause of death was a pyæmic abscess, for which he was attended by his former colleague, Mr. Walter Spencer.

#### MATTHEW LEDWITH, M.A., M.Ch., M.B., Q.U.I.

We regret to announce the death of Dr. M. Ledwith, of Mullingar. The deceased gentleman was taken suddenly ill on the 28th ult., when he was found to be suffering from pneumonia, which terminated fatally in forty-eight hours. Deceased was very popular in the district, where he commenced medical practice some seven years ago. He was medical attendant, as civilian surgeon, to the troops stationed in the town, and for years past was surgeon to the National Foresters.

#### SIR JAMES WILSON AGNEW, M.D.

A REUTER telegram, dated Hobart, Nov. 9, says:—"Sir James Agnew, formerly Premier of Tasmania, died yesterday. The deceased, who settled in Tasmania about sixty years ago, was universally respected." Sir James Wilson Agnew, M.D., J.P., was admitted a member of the Royal College of Surgeons (England) in 1838, and M.D. of Glasgow University in 1839. Soon afterwards he emigrated to Tasmania, and for many years practised his profession in Hobart. He became a member of the Legislative Council in 1877, and was elected Premier and Chief Secretary of the colony in 1886. He was vice-president and hon. secretary of the Royal Society of Tasmania, and for many years a member of the Tasmanian Council of Education, and a member of the Council of the Tasmanian University.

### Literature.

#### MEMOIRS OF SIR JAMES PAGET, BART. (a)

THIS charming work will appeal not only to all who had the privilege of knowing Sir James Paget and to all "Bart's men," but to the whole medical profession. It is not only the story of an extraordinarily arduous career, but it is full of anecdote and quotations from the works and addresses of an undoubted master mind. Among the reasons which contributed to his successful career, Sir James himself attributes the early study of botany. It introduced him into the society of studious and observant men; it encouraged the habit of observing, of really looking at things and learning the value of exact descriptions; it educated him in habits of orderly arrangement, and although this knowledge was

in itself useless to him in after life, the discipline of acquiring it, he says, was beyond price. A certain education, too, in the fine arts helped him to see in things more than others could see; it strengthened the power of remembering things seen, and made it easy to illustrate his lectures. "The facility of speaking had so great influence on my career, it helped to gain for me so many appointments in good repute, and was judged to be a sign of so much more mental power than it really implied that I may venture to say more about it. I never spoke on any considerable occasion without careful preparation, at the best preparing every word long before, and learning, if I could, every word by heart. Indeed, as between speaking and writing, the choice of words for speaking seems to me the more important. It is not prudent to wish for extempore speaking if it cannot be done more than *pretty well*, for 'pretty good' extemporaneous speaking is hardly more pleasing than are pretty good eggs." Sir James goes on to say that he was very sensitive to ridicule and inattention, and very anxious to be in good repute with the best judges. These things made him on all but the commonest occasions very careful and fearful of failure, anxious, and often very nervous. "I could," he remarks, "conceal my nervousness, but it always weighed upon me." &c.

Some figures with regard to Sir James Paget's career may be interesting. His schooling cost eight guineas per annum, his apprenticeship 100 guineas. He got engaged on nothing a year as soon as he was qualified, and waited for his wife eight years. His earnings from private practice for the first sixteen years did not exceed £100 per annum. He learnt how to subdue hunger by raisins and dates. On giving up operating his income dropped from £10,000 to £7,000. If he had died before he was forty-seven he would have left no savings, and his widow and children would have been in extreme poverty, and they would have still been poor had he died at sixty. He always worked sixteen hours a day, and had pneumonia six times between 1861 and 1870. He travelled from 5,000 to 8,000 miles a year. Sir James noticed "that there was much larger loss of practice after every illness than that which was directly due to inability to work. It often made me think that idiocy would be less hindrance to success than invalid health was." At forty-seven the first real holiday for seventeen years was taken. Sir James never learnt any sports or active games, and had not the least belief in the opinion that a good man is likely to be the better for being a good rower or in any way a distinguished athlete. Rather, perhaps, by giving more opportunity for the satisfaction of the love of praise, they tend to diminish, in some minds, the ambition for success in the proper business of life. He believed that those have done best who have had the most single mind for the proper duties of their lives, and have set no limit to their work but the limit of their strength. The work is so interesting that one hardly knows what to note. Possibly, Sir James Paget had his limitations. Who has not? His highest excellence was not in operating, but in his calculation of all the complex forces at work on a patient—heredity, temperament, habits, previous illnesses; in his insight into the variations and abnormalities of disease, and in his pathological knowledge of the characters tendencies, and developments of surgical diseases.

#### MCCALLIN ON MEDICAL JURISPRUDENCE. (a)

THIS book contains a useful bird's eye view, so to speak, of the essentials of medical jurisprudence. It deals concisely with its subject, which the author defines as "the legal aspect of a medical practitioner's work." The information thus given should certainly be in the possession of every medical man, and may be conveniently brought back to the memory by reading this little volume. We note, however, on page 8 that speaking of the fees payable to a medical witness, no mention is made of the special fees often paid to expert wit-

(a) "Sir James Paget. Memoirs and Letters." Edited by his son, Stephen Paget, F.R.C.S. With Portraits and other Illustrations. London: Longmans, Green and Co. 1901. Price 12s. 6d.

(a) "Medical Jurisprudence: An Introduction to." By William McCallin, M.L., D.P.H., Barrister-at-Law, Inner Temple. London: Baillière, Tindall and Cox. 1901. 4s.

nesses in criminal and other courts. Much of the advice given is extremely sound, as that following the statement that "the cause of death is not conclusively settled by the verdict of a coroner's jury, as far as a life insurance policy is concerned. Therefore, if a medical witness, at the inquest of a person whose life has been insured, indulges in indefinite statements and vague opinions, he may afterwards be picked to pieces in the witness-box in another court." Or, again, touching the making of wills, a point that is sure sooner or later to crop up in the experience of every general practitioner, the writer says:—"If, through urgency, a medical attendant has to write his patient's will, the simple rule is to ascertain the extent and nature of the testator's property, to state as plainly and as fully as possible the manner and order in which he wishes to dispose of it, and to avoid ambiguity and the use of technical language. It is usual and proper to appoint one or more executors. The law does not require any particular form, provided the testator intends the instrument to take effect after his death. To be validly executed a will must be signed, at the foot or end of it, by the testator, or by some other person on his behalf, in his presence and by his direction, and such signature must be made or acknowledged by the testator in the presence of two or more witnesses present at the same time, who must subscribe their names as witnesses in the presence of the testator." The latter half of the book is devoted to a concise description of the common poisons and their detection. This little volume may be recommended as an accurate and trustworthy sketch of the leading facts and principles of the subject with which it deals, and should be useful both to lawyers and to medical men who are interested in medico-legal matters.

#### HEATH ON MINOR SURGERY, Etc. (a)

THIS is one of the books with which no student, or even practitioner, would willingly dispense. Its usefulness has augmented *pari passu* with its increase in size, but even in its present up-to-date form its dimensions have not been allowed to become unwieldy. Mr. Bilton Pollard has been entrusted with the task of bringing the work into conformity with the requirements of modern surgery, and no fault can be found with the way in which he has fulfilled it. The work is replete with useful practical instruction in details, and it embraces the whole realm of surgery. The chapter on anaesthetics by Dr. Dudley Buxton is, perhaps, the least satisfactory. He lays it down, towards the end of the chapter, that "chloroform is best given by a regulating inhaler," but he prefaces his remarks by the statement that "chloroform may be given by the open method," a dangerous permission which, in practice, is responsible for a very large proportion of the fatalities caused by this powerful but, when properly administered, fairly safe anaesthetic. Nowhere does he insist on the risk inseparable from this rough and ready unscientific mode of administration, nor does he lay emphasis on the fact that struggling is due to a sense of impending asphyxia, itself the immediate result of too large a proportion of chloroform vapour. So long as this teaching prevails, so long we shall have to deplore almost daily catastrophes from chloroform narcosis, well-nigh invariably determined by "the open method."

The illustrations are numerous and excellent, and the present edition is certain to maintain the popularity which its predecessors for the last quarter of a century have gained.

#### MURRAY ON DISEASES OF THE THYROID GLAND. (b)

DR. MURRAY writes for a large class of readers; in fact for all, whether students or practitioners, who can benefit

(a) "A Manual of Minor Surgery and Bandaging." By Christopher Heath, F.R.C.S., LL.D., Consulting Surgeon to University College Hospital, &c. Revised by Bilton Pollard, F.R.C.S., Surgeon to University College Hospital. Twelfth Edition. London: J. and A. Churchill, 1901.

(b) "Diseases of the Thyroid Gland." Part I.: Myxœdema and Cretinism. By George E. Murray, M.D., F.R.C.P., &c. London: H. K. Lewis, 1901.

by reading a well-written book on a most interesting group of diseases. For students such books are invaluable. A chapter in a text-book may contain all the facts, but the illuminating power of a monograph such as this, which takes but little longer to read and digest, is, without exaggeration, tenfold. The opening chapter, without being pedantically complete, gives what is perhaps an adequate account of the structure and functions of the gland, and review of the progress of knowledge in this subject during the last quarter of a century; the two remaining chapters in this, the first part of the work, contain illustrated accounts of the diseases myxœdema and cretinism. If in the next edition Dr. Murray is enabled to include the final results of the experiments which he had begun when writing this one, upon the differentiation of the functions of the parathyroid glands as distinct from the thyroid, his book may become a valuable addition to the scientific literature of the subject.

LITERARY NOTES.—Professor W. H. Thompson, of Queen's College, Belfast, has translated the work of Professor Pawlow, of St. Petersburg, to which the Nobel Prize was awarded, entitled "The Work of the Digestive Glands." The publishers, Messrs. Chas. Griffin and Co., of London (through the translator) have arranged with the distinguished author for the publication of the English edition, which will include the later volume, entitled "The Experiment," &c., together with the notes of the most recent researches of Professor Pawlow, and will constitute the sole authorised edition for England and America of this important work.

A NEW medical journal has just made its appearance, called *The Midland Medical Journal*, which is described as the official organ of the Birmingham and District General Practitioners' Union. It is to be published monthly, and the initial number, which is of very modest compass, contains an "Introduction" by Sir James Sawyer, formerly editor of the *Birmingham Medical Review*, and contributions appear from Dr. Arthur Foxwell, Dr. E. E. Hamilton Williams, Dr. T. Sydneg Short, Dr. E. D. Kirby, and Dr. W. H. Line.

THE well-known and decidedly popular American text-book of "The Principles and Practice of Medicine," by Dr. Osler, is now issued in this country by two firms: Mr. Kimpton, of London, and Mr. Pentland, of Edinburgh, the only apparent variation being in the colour of the binding. The book was formerly published at 21s., but British competition has reduced the price to 18s., and thereby the medical public are benefited by a squabble between publishers.

### Medical News.

#### Anæsthetic Fatalities.

A DEATH under ether is reported as having occurred at the Royal Surrey County Hospital, Guildford, last week, following one chronicled by us last week in London. The victim was a labourer 35 years of age, and was undergoing an operation for the relief of acute intestinal obstruction. Death was attributed by the medical witnesses to the patient's condition, and not to the anaesthetic. It was mentioned that this was the only catastrophe of the kind at the hospital since it was opened.—A death under chloroform at the Royal Free Hospital, London, was the subject of an inquest on the 4th inst., the victim being a man, æt. 52, who was being operated upon for the removal of a growth in the neck. Miss Blake, who administered the anaesthetic, stated that this was the first fatal occurrence in 2,600 cases.—Another death under chloroform occurred at Liverpool, in private practice, the victim being a man, æt. 30, about to be operated on for fistula. It was stated that only 40 to 50 minims of the drug had been given. We gather that in both these cases the so-called "open method" was employed, and one would like to know why it is that anaesthetists persistently decline to make use of a regulating inhaler.

The Medical Service of the London School Board.

THE London School Board have adopted a new mode of regulations in anticipation of the resignation of Dr.

W. E. Smith, which takes effect in April next. It was resolved: "That the staff of the medical department (with their duties) be constituted for the present, subject to alteration, as follows:—1. Examination of male candidates for employment, visits to schools where there has been an outbreak of infectious diseases, and generally to do such work conduct such inquiries, and give such advice as may be required of him from time to time. 2. Assistant (lady), half-time.—Examination of female candidates for employment. Crippled children. Examination of defective children in spare time. 3. Two assistants, half-time.—Examination of defective, blind, and deaf children. Any spare time to be given to visiting schools in which there has been an outbreak of infectious disease. In advertising, specify skill as oculist and aurist as essential in one case, and experience of feeble-minded children in the other. 4 and 5. Two oculists, temporary, for one year.—For the purpose of testing the eyesight of the children in senior departments. Part of their duty will be to correct errors of refraction, and to make arrangements with opticians, similar to those made at ophthalmic hospitals, for providing the necessary glasses at hospital rates on payment by the children. A further part of their duty will be to look into all cases of disease or affections of the eyes, contagious or otherwise.

#### Gift to the Royal College of Physicians of London.

The College has accepted a legacy of £2,000 from Mrs. Fitzpatrick, for the purpose of endowing a lectureship on the history of medicine, in memory of her late husband, Dr. Thomas Fitzpatrick.

#### Medical Suicide.

An inquest was held a few days since on the body of Dr. Adam Argo, who committed suicide by taking poison while of sound mind. The deceased had been in practice for some time at Arlesey, North Herts.

#### Irish Medical Schools' and Graduates' Association.

The autumn general meeting of the Association will be held in London, at the Cecil Hotel, on Wednesday, November 27th, at 6.30 p.m. On the same evening the Association will dine at the Victoria Hall of the Cecil Hotel, at 7.15 p.m., when the President, Dr. William Alexander, will take the chair. The guest of the Association will be Sir Charles Crosthwaite, K.C.S.I. (late Lieutenant-Governor of the North-West Provinces of India).

#### University College, Bristol.

The following prizes have been awarded in the medical department:—Summer session:—Pathology, prize, J. Crétin. Medical Jurisprudence, certificate, C. Corfield. Operative Surgery, prize, C. Corfield. Midwifery, prize, A. Short. Practical Medicine, Surgery, and Midwifery, certificates, W. Webb and A. Short. Practical Physiology, prize, W. H. J. Pinniger; certificates, W. Ring, R. Bodman, C. E. K. Herapath, F. Perry, W. Lennox, H. Goodden, B. Vaughan, and F. G. Bergen. Pharmacology, prize, S. Hayman; certificate, T. Pratt. Materia Medica, prizes, F. G. Bergin and W. Pinniger. Practical Chemistry, prizes, C. Plumley and W. King; certificates, R. Lecky, B. Vaughan, and G. H. Smith. Anatomy, prize, W. Pinniger; certificates, F. W. Perry, A. Thomas, and J. S. Avery. University Entrance Scholarship (£50), C. S. Rivington. Lady Haberfield Entrance Scholarship (£30), A. E. Iles; Martyn Memorial Pathological Scholarships of £10 each, A. B. Short and C. Corfield; Tibbits Memorial Prize (£9 9s.), P. W. White; Committee's gold medal for the student of the fifth year who has most distinguished himself, J. E. Sparks; Augustin Prichard Prize (£6 6s.), C. J. Taylor; Clarke Scholarship (£15), A. Short; Henry Marshall Prize (£12), A. Short; Sanders Scholarships, J. E. Sparks (£22) and C. Corfield (£11); Special Midwifery Certificates, W. Blatchford, J. Clayton, F. Rudge, and C. J. Taylor.

#### Vital Statistics.

The deaths registered in the week ending November 2nd in 37 large towns of the United Kingdom corresponded to an annual rate of 17.8 per 1,000 of their aggregate population, which is estimated at 11,463,026 persons in the middle of this year:—  
Belfast 22, Birkenhead 17, Birmingham 20, Blackburn 23,

Bolton 14, Bradford 16, Brighton 13, Bristol 15, Burnley 22, Cardiff 11, Croydon 8, Derby 15, Dublin 22, Edinburgh 16, Glasgow 21, Gateshead 14, Halifax 17, Huddersfield 18, Hull 16, Leeds 17, Leicester 11, Liverpool 21, London 17, Manchester 19, Newcastle-on-Tyne 21, Norwich 15, Nottingham 13, Oldham 17, Plymouth 15, Portsmouth 14, Preston 22, Salford 22, Sheffield 20, Sunderland 18, Swansea 10, West Ham 18, Wolverhampton 12. The highest annual death-rates per 1,000 living, as measured by last week's mortality, were:—From measles, 1.2 in Sheffield, 1.9 in Norwich, and 3.3 in Blackburn; from whooping-cough, 1.4 in Sunderland; from fever, 1.0 in Halifax and 1.4 in Salford; and from diarrhoeal diseases, 1.4 in Preston and in Sunderland. In none of the large towns did the death-rate from scarlet fever reach 1.0 per 1,000. The 78 deaths from diphtheria included 36 in London, 6 in Liverpool, 4 in Glasgow, 4 in West Ham, 4 in Sheffield, and 3 each in Edinburgh and Bristol. Six deaths from small-pox were registered in London and 1 in Plymouth, but not one in any other of the large towns.

## Pass Lists.

### University of Glasgow.

At the graduation ceremony on Thursday last, the M.D. Degree, with honours, was bestowed on David L. Cairns, M.B., Ch.B.

M.D. Degree, with Commendation.—John Aitken, M.B., Ch.B., Arthur J. Ballantyne, M.B., Ch.B., George Coats, M.B., Ch.B., John Henderson, M.B., Ch.B., James D. R. Munro, M.A., M.B., C.M.

Ordinary Degree.—Agnes F. Blackadder, M.A., M.B., Ch.B., William B. Brodia, M.B., C.M., William Cullen, M.B., C.M., Robinson S. Dixon, M.B., C.M., Charles H. Hall, M.B., C.M., John H. Lyell, M.B., C.M., Eva M'Call, M.B., Roderick: A. MacLeod, M.B., C.M., Edward J. Morris, M.B., C.M., William Roxburgh, M.B., C.M., Alexander B. Sloan, M.B., Ch.B., Hugh G. Stewart, M.B., C.M., Ernest Watt, M.B., Ch.B.

Bachelor of Medicine (M.B.) and Master in Surgery (C.M.).—George W. Milne.

Bachelors of Medicine (M.B.) and Bachelors of Surgery (Ch.B.).—Robert W. Auld, John J. Young Campbell, Edward S. Chapman, George H. Clark, Duncan J. Fletcher, Thomas Forsyth, William Gemmill, James D. Gourlay, Archibald Gow, Janet B. Higgins, Alexander Linn, Walter J. M'Feat, William F. M'Glashan, Karen Myhre, Robert Orr, Mary Potter, Andrew Reid, Elizabeth N. MacBean Ross, John Stewart, M.A., Robert Rennie Swan, Robert Geo. White, M.A., B.Sc., James Wilson, William Robertson Wylie, Henrietta Young.

### Dublin University School of Physic.

The following candidates have passed the medical examination in the undermentioned subjects:—

Anatomy and Institutes of Medicine.—High marks: Cunningham, M'Neight, eq.; Wade, Pearson; Campbell, J. H. C. Thompson, Walsh, Wilmot, eq.; Walton, Wyatt.

Physics and Chemistry.—High marks: Nunan, Usher, eq.; Alexander, Corley, Powell; Willington, Elliott, eq.; M'Entire, M'Creery; Harnett, Stewart, eq.; Egan, M'Quaide, MacFetridge, Mitchell.

Botany and Zoology.—Ferguson, Leech, Hogan; Atwell, MacFarlane, Moyers, eq.; Creever, Elliott, Greene, J. H. Elliott, DuBedat, Egan, Garstin.

Conjoint Examinations in Ireland by the Royal College of Physicians and Royal College of Surgeons.

The following candidates have passed the supplemental preliminary examination of the Royal College of Physicians and Royal College of Surgeons:—

Honours in Order of Merit.—N. Y. Stewart, J. B. Hobson, E. H. McGillicuddy, M. Kennedy.

Pass Alphabetically.—F. J. Adams, Wm. Anderson, S. Black, A. L. Clarke, M. Cohen, Miss K. Dillon, J. J. Dwyer, P. Ferguson, R. H. Ford, J. C. Healy, J. Humphreys, D. Johnston, J. B. Leaky, F. J. Morris, R. H. MacCrea, S. R. Macnamara, T. O'Brien, E. B. M. Sullivan, J. Walker, C. L. Waters, J. Walsh, C. H. Wilson.

## Notices to Correspondents, Short Letters, &c.

**CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

### OUR ARMY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I don't know whether it has struck others besides myself, but it seems very clear that the head of the British Army, at the present time, is "General Paralysis."

I am, Sir, yours truly,

LONG BANGE.

MR. WALTER JACKSON (Connemara).—The samples have been received, and will be noticed in due course.

### THE APOTHECARIES' HALL AND THE UNIVERSITY QUESTION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR, Should it be decided, as a result of the report of the University Commission, to establish a new University in Ireland, surely some arrangement might be made whereby it would form a licensing and examining board conjointly with the Apothecaries Hall. Such a scheme would obviate the necessity of increasing the number of licensing bodies—a most undesirable thing; and should also render unnecessary the importation by the Apothecaries' Hall of examiners nominated by the General Medical Council. I presume that the Conjoint Board so formed would grant a lower qualification such as L.M., L.S., and L.A.H., whilst the ordinary M.B. would be obtainable as a result of further examination. Certainly such an arrangement would tend to the betterment of Irish medical examination.

I am, Sir, yours truly,

J. C. McWALTER. M.A., D.P.H.

Dublin, Nov. 5th, 1901.

UBIQUE.—Your letter is unavoidably held over this week and will appear in our next. We cannot insert any more letters on the subject, which might, in our opinion, be allowed to drop.

### "HYDROPS BRONCHIALIS" AND THE BRONCHITIS KETTLE.

OUR publisher has received several applications for copies of this journal for January 25th, 1902, in consequence of the letter of Dr. Pearse in our last week's issue. This number, containing an article specially written for these pages by the late Sir B. W. Richardson, M.D., F.R.S., on the above subject, has been out of print for some years, but in accordance with the request of many of our readers we propose reprinting it in an early number.

M. P.—The matter has not escaped our attention, but we are not yet in possession of the necessary data. We hope to be able to deal with it in the near future.

### AN AMBIGUOUS TESTIMONIAL.

Truth has unearthed from among the testimonials published by the New York Institute of Science the following, which reminds one of the testimonial given (in *Punch*) to a certain soap:—"Dear Sir, - I wish to state my case as best I can. *The day I commenced your treatment I had paralysis*, which deprived me of the use of my right hand. My right leg was also considerably affected." The treatment, it is suggested, got to work promptly enough in this case. The patient goes on to state that she is getting over it by degrees. She may think herself lucky!

## Meetings of the Societies.

### LONDON.

WEDNESDAY, NOV. 13TH.

DERMATOLOGICAL SOCIETY OF LONDON (11, Chandos Street, Cavendish Square, W.).—5.15 p.m. Demonstration of Cases of Interest.

HUNTERIAN SOCIETY.—(London Institution, Finsbury Circus, E.C.).—8.30 p.m. Discussion on Small-pox and Vaccination, in which Dr. W. A. Bond, Major Greenwood, and Dr. MacCombie will take part. Paper:—Dr. Major Greenwood: The Present Position of Small-pox and Vaccination. Dr. MacCombie: The Differential Diagnosis of Small-pox, with remarks on Prodromal Eruptions and Vaccination.

THURSDAY, NOV. 14TH.

HARVEIAN SOCIETY OF LONDON (Stafford Rooms, Titchborne Street, Edgware Road, W.).—8.30 p.m. Mr. B. Browne: Twenty-five Years' Experience of Urinary Surgery (Harveian Lecture).

BRITISH GYNECOLOGICAL SOCIETY (20, Hanover Square, W.).—8 p.m. Specimens will be shown by Dr. H. Macnaughton-Jones, Mr. E. O'Callaghan, and others. Paper: Dr. H. Snow: Prophylaxis in Gynaecology.

FRIDAY, NOV. 15TH.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN (11, Chandos Street, Cavendish Square, W.).—5.30 p.m. Cases and Specimens will be shown by Mr. A. H. Tubby, Dr. D. Walsh, Mr. S. Stephenson, Dr. E. Cantley, and Mr. W. G. Nash. Papers:—Dr. E. Cantley: Observations on the Etiology and Morbid Anatomy of Tuberculous Meningitis. Mr. G. Pernet: A Family Epidemic of Impetigo Contagiosa Bullosa.

### DUBLIN.

WEDNESDAY, NOV. 13TH.

Royal College of Physicians, Special Meeting, 4.30 p.m.

FRIDAY, NOV. 15TH.

Royal Academy of Medicine, Dublin, Medical Section. Intro-

ductory Remarks by the President. Papers: (1) Dermatitis Gangrenosa, by Dr. Finny; (2) A Case of Paranoia Hallucinatoria, by Dr. Conolly Norman.

## Appointments.

BARTON, G. A. H., M.B.C.S., L.R.C.P., Honorary Anaesthetist to the City Orthopedic Hospital.  
BREWERTON, ELMORE, F.R.C.S.Eng., Assistant Surgeon to the Royal Westminster Ophthalmic Hospital.  
BROWN J. WALTER, M.B., B.Ch., R.U.I., House Surgeon to the Royal Victoria Hospital, Bournemouth.  
EADES, A. J., L.R.C.P. and S.I., Senior Assistant Medical Officer the County Asylum, Winwick.  
HADLEY, CLEMENT, M.B.C.S., L.K.Q.C.P.I., Certifying Surgeon under the Factory Acts for the Shilton District of Warwick.  
HALL, J. BASIL, M.C.Cantab., Honorary Surgeon to the Bradford Royal Infirmary.  
HOWARD, VINCENT, M.B.C.S., L.R.C.P., Certifying Surgeon under the Factory Acts for the Borough and District of Buckingham.  
HOOG, JOHN A., L.R.C.P., M.B.C.S., Medical Officer of Health to Castle Donington Rural District Council.  
JACKSON, D., M.D.Glaag., Medical Officer of Health for the Urban District of Hexham.  
LANGRAN, W., L.R.C.P., L.R.C.S. Edin., Medical Officer of Health for the Axminster Rural District.  
LLEWELLYN, J. M.B.C.S., L.S.A., Medical Officer for the Sherburn District of the Scarborough Union.  
MURRELL, CHRISTINE M., M.B., B.S.Lond., Assistant House Physician to the Royal Free Hospital, London.  
PARRY T. W., M.B., B.S.Cantab., Certifying Surgeon under the Factory Acts for the Youlgreave District of Derbyshire.  
WAKE, GEORGE STEPHEN, M.B., B.S.Darb., L.R.C.P., M.B.C.S., Medical Officer for the Fourth District of the Barnstable Union.

## Vacancies.

Birkenhead Children's Hospital.—House Surgeon. Salary £100 per annum, with board, residence, and laundry. Applications to E. H. Tilby, Hon. Secretary, 52, Grosvenor Road, Birkenhead.  
Brentford Union.—Assistant Medical Superintendent. Salary £100 per annum, with furnished apartments, rations, washing, &c. Applications upon forms to be procured of W. Stephens, Clerk to the Guardians, Union Offices, Isleworth, W.  
Chester General Infirmary.—House Physician. Salary £90 per annum, with residence and maintenance in the house. Further particulars may be obtained on application to the Secretary.  
County Asylum, Mickleover, Derby.—Senior Assistant Medical Officer. Salary commencing at £130, with board, washing, &c. Also Junior Assistant Medical Officer. Salary £110 rising to £130 per annum, with furnished apartments, board, washing, and attendance. Applications to the Medical Superintendent.  
County Asylum, Prestwich.—Junior Assistant Medical Officer. Salary commencing at £150, with board, &c. Applications to the Medical Superintendent.  
Glamorgan County Asylum, Bridgend.—Fifth Assistant Medical Officer. Salary £170, with board, lodging, and washing. Applications to the Medical Superintendent.  
Manchester Corporation, Moseley Fever Hospital. First Medical Assistant, at £180 per annum, with board and lodging. Applications to the Chairman of the Sanitary Committee, Public Health Office, Town Hall, Manchester.  
Newcastle-on-Tyne Dispensary.—Visiting Medical Assistant Salary commencing at £160. Forms of application of the Resident Medical Officer at the Dispensary.  
Sheffield Royal Infirmary, Casualty Officer. Salary £100 per annum, with board, lodging, and washing. For duties of post apply to the Secretary.  
Somerset and Bath Lunatic Asylum, Cotford, Taunton. Assistant Medical Officer. Salary £150 per annum, with furnished apartments, board, fuel, lighting and washing. Applications to the Medical Superintendent.

## Births.

EVANS.—On Nov. 3rd, the wife of O. C. Penrhys Evans, M.D., of 22, Church Street, Kidderminster, of a daughter.  
FRANKISH.—On Nov. 6th, the wife of W. J. Frankish, L.R.C.P. Lond., &c., 102 Sloane Street, London, of a son.  
GIBBS.—On Nov. 8th, wife of Charles Gibbs, F.R.C.S., 115, Harley Street, London, W., of a daughter.

## Marriages.

COWARD—BRUSHFIELD.—On Nov. 6th, at St. Peter's Church, Budleigh-Salterton, Devon, Ernest G. Coward, M.B., of Almondsbury, Huddersfield, youngest son of the late J. Eyres Coward, M.B.C.S.E., to Eleanor Millar, youngest daughter of T. Nandaud Brushfield, M.D., of Budleigh-Salterton.  
EWART CARTER.—On Nov. 7, at St. Mary Abbot's Church Kensington, J. H. Ewart, M.D., Abershaw, Folkestone, second son of the late Colonel C. H. Ewart, I.S.C., to Florence, daughter of the late Capt. Willoughby Carter, of Annaghkeen, co. Galway.  
GORDON-WILSON—BISCH.—On Nov. 2nd, at St. John's Church Blackheath, Alexander Gordon-Wilson, M.D. Lond., F.R.C.S.Eng., of Lyell House, Folkestone, to Louisa Mary Friederick Bisch.  
SAVILL—BLACKADDER.—On Nov. 2nd, at St. Mary Magdalene's Church, Dundee, Thomas D. Savill, M.D.Lond., to Agnes F. Blackadder, M.A. St. And., M.D.Glaag.



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### THE PERSONAL FACTOR IN TUBERCULOSIS. (a)

By SIR DYCE DUCKWORTH, M.D.,  
F.R.C.P.Lond., F.R.C.P.I.,

Physician to St. Bartholomew's Hospital.

THE author prefaced his remarks by pointing out how at the present time the whole of medicine, and in particular the science of pathology, were dominated by bacteriological ideas.

Amidst the enthusiasm with which these momentous discoveries in this field had been received, he could not but feel that some important, although older, doctrines had been lost sight of. Respecting the modern views as to the nature of tuberculosis, he felt that too little regard was now paid as to the peculiarities of the host, and perhaps too much to those of the infecting parasite. So much was this the case that modern writers disregarded the question as to the particular habit of body which presented the most favourable soil for such infection. Those whose studies were confined to pure pathology might, perhaps be pardoned if they paid little heed to the question of the personal factor in disease, but inasmuch as physicians had to treat *patients* and not *diseases* they could not ignore the intimate relations between the host and this infecting element. The condition of body which was most prone to become invaded by tuberculosis was that long known as the scrofulous or strumous diathesis. The doctrine of the diatheses received little or no attention in these days, but bacteriology had not done away with these textural conditions, although it had temporarily overshadowed the recognition of them. The modern doctrine was laid down that "scrofula was tuberculosis."

This the author absolutely denied, and he maintained that it was possible to be scrofulous throughout life without becoming tuberculous. The essential character of scrofula was a textural vulnerability to irritation of all kinds, and especially to tuberculous invasion. Scrofulous persons reacted badly to all morbid processes, and all inflammatory disorders

in them tended to be lingering and rebellious to treatment. Many of the ailments from which they suffered were of a non-tuberculous character. The vulnerability of their lymphatic system, which was a marked feature, did not depend on tuberculosis.

The opinions of Simon, Watson, Paget, and others were given in illustration of these contentions, and that of Virchow, to the effect that vulnerability was the keynote of scrofula, was enforced. The teaching we were now asked to accept was that there was no scrofula without tuberculosis, and that if any individual presented signs of struma he was already tuberculised. This was a vain doctrine, and set forth in defiance of obvious clinical observations. Strumous conditions supervened on debility and continued struggles against nature. The textural frailty, with its peculiarities and proclivities, powerfully modified the character and progress of any malady which occurred in those thus impressed.

It was next shown how persons of gouty predisposition were thereby largely immunised against tuberculosis, the offspring of the gouty manifesting none of the peculiar delicacies of the strumous. Tuberculosis when it occurred in the gouty made little progress as a rule, and tended to obsolescence. What was bad for the gouty was good for the strumous. The course of a tuberculous process when it occurred in the gouty was largely modified, and fibrotic changes were associated with it. In the strumous the lesions tended to soften rapidly and disorganise the affected sites. Hence it was obvious that there were at least two pathogenic factors to be regarded in any case of tuberculosis—(a) the host, and (b) the infecting parasite. The younger pathologists now "reckoned without their host." If both factors were recognised, as clinical medicine required, it became obvious that much of the preventive procedures against tuberculosis must relate to the personal factor, and that our duty was to fortify the host against invasion, as well as to intercept and destroy the invader. It was probable that the best preventive measures would be found in strenuous efforts to render such persons as were prone to infection as immune as we could make them by securing for them appropriate dietary and the best hygienic environments. Lastly, a protest was made against the modern idea of "curing" tuberculosis. All we could do was to place the patient in conditions favourable to an *arrest* of the process. The malady was so often arrested as tuberculosis, but none were more ready to relapse at any period within the lifetime of the patient. A better comprehension of the textural proclivities of the individual might enable us to frame a sounder prognosis in respect to liability to relapse after the occurrence of an arrest. More than this we could not do. In any case, bacteriology was not the "be all" and "end all" of clinical medicine as it was so commonly supposed to be.

(a) Abstract of paper read before the Liverpool Medical Institution, October 24th, 1901.

## The Harveian Lectures, 1901.

TWENTY-FIVE YEARS' EXPERIENCE  
OF  
URINARY SURGERY IN ENGLAND.  
DELIVERED BEFORE THE HARVEIAN SOCIETY OF  
LONDON, NOVEMBER 7TH, 1901,  
By G. BUCKSTON BROWNE, M.R.C.S.Eng.

## ABSTRACT OF LECTURE I.

AFTER some introductory remarks the author proceeded to consider the question of urinary fever, which, he said, is at the bottom of the whole of urinary surgery. At its outset this fever is purely a suppression of urine, varying from merely transitory to the most complete and absolute, due to the inhibition of the action of the kidney from urethral shock. The nerve supply of the urethra is remarkably generous, and the penis itself is most intimately connected in this way with the rest of the body. An excellent illustration of the very liberal nerve supply of the urethra and of its intimate connection with the rest of the body is afforded by the study of the marvellous phenomenon of erection. In the prechloroform days many a man has died upon the operating table simply from the shock of an amputation of the penis. If a bougie is passed up on the average young man in the standing posture, he will, in many cases, in a few moments, be writhing on the floor in what is practically an epileptiform convulsion; let him be put to bed, and a good perspiration encouraged, and he will soon be well; but if an old man be subjected to a similar shock he does not always recover. Many surgeons of sufficient experience will be able to recall some case of an elderly man who has had a catheter passed, and who has never secreted another drop of urine, and has died. The hypodermic injection of morphia an hour before passing the bougie has been followed by the happiest results. In another (elderly) patient I was fain to perform my operation of internal urethrotomy at one sitting, under an anæsthetic, so marked was the shock following the catheterisation. There was no fever, and the patient lived for several years in perfect urethral comfort. We often find in practice that the stricture patient can bear a certain sized bougie well, but if an instrument at all larger is used its introduction is sure to be followed by fever. Women and children curiously enough never suffer from this fever. These facts prove that the fever is due to nervous shock, to urethral shock. The male adult's urethra is a sexual as well as a urinary tract, whereas the urethra of the woman and child is a urinary tract only, and they consequently do not suffer. Deal gently with the male urethra and all will probably be well; use violence and the results may be disastrous. Narcotise the patient with opium or with chloroform and you may use violence up to a certain point, and still have no fever. You may often cut the urethra, if you do not stretch it, and have no fever. You may one day pass a catheter and have no fever, and next time and on the same patient you may not be so skilful and successful, you may blunder, and hurt the patient and make him bleed, and severe fever will follow. Then again, certain nationalities are more prone to this fever than others. The French are certainly much more susceptible than the Germans, and among the British the Irishman is far more likely to suffer than the Englishman. These more susceptible people are certainly the most nervous, this term being used in its highest and best sense. Even among people of the same nation, the more highly trained, the more educated,

the more refined the subject, the more likely is he upon due provocation to suffer from this fever. All these clinical facts prove that the onset of urinary fever is due to nervous urethral shock conveyed to the secreting tissues of the kidneys by the urethral nerves and inhibiting the secretory action of these organs to a lesser or greater extent, producing suppression of urine, from the most complete and absolute to the slightest and most transient possible. In fact, urinary fever is suppression of urine. If the suppression of urine is complete or considerable, the kidney naturally becomes engorged with blood, inflammation ensues, and in bad cases suppuration follows, and the patient frequently sinks into a state, often and deservedly called typhoidal, and dies. No doubt this suppuration is more likely to occur if there be surgical impurity in the bladder, and hence the necessity for careful antisepticism from the very commencement of any surgical urinary treatment. My view, therefore is, that while this urinary fever may undoubtedly run on and develop into septicæmia, it is not, primarily, blood poisoning.

In 1875, when I began practice, a man with a stone in his bladder was subjected either to perineal lithotomy or to lithotripsy, and occasionally large quantities of small stones were simply washed out of the bladder by Clover's apparatus, a good instance of this latter operation being published by the late Mr. John Foster in the *Lancet* for October 10th, 1874, four years before Prof. Bigelow published his paper on Litholapaxy. The woman with a stone was generally cut, and boys and girls were always cut. Lithotripsy was unquestionably an unpopular operation. The general surgeon was opposed to it, although Liston, Brodie, and Fergusson had all given it their countenance. Sir Henry Thompson, in his time, was almost alone in this country as an advocate and champion of the operation, urging its adoption not as a substitute, but as a complement to the operation of lithotomy. The early lithotritists, of course, had to practise without anæsthesia, and they found that patients bore badly the repeated introduction of instruments, and that the more instrumentation they underwent the more severe was the resulting urinary fever. This led Civiale, the father of lithotripsy, to inculcate the importance of short sittings and of the employment of great gentleness, and it was with this teaching that Thompson was imbued when he began his surgical career in London. This principle of gentleness is a great one, and is still of vast importance, although the introduction of anæsthetics has made it subject to certain modifications. The lithotrites of 1860 were the ingenious and unhandy instruments of Brodie and Fergusson, and the perfect instrument of modern days is entirely due to the suggestion of Thompson, and to the mechanical genius of the elder Weiss. No one but the lithotritist can realise the value of the cylindrical handle which they introduced. For some years Sir Henry Thompson practised lithotripsy, removing much of the debris between the blades of the lithotrite, and leaving the rest to be expelled by Nature's efforts, and it was not until 1866 that the late Mr. Clover's name began to be associated with the operation of lithotripsy. In the *Lancet* of May 11th of that year he first described his apparatus for evacuating the debris after the crushing of a stone. No one has ever done sufficient honour to the memory of Mr. Clover. He was an Englishman educated at University College Hospital, London, full of ingenuity and resource. His inventions were numerous, and he was a pioneer in the modern art of anæsthesia, and in that art his inventions are still in use and are of great value. In turning his attention to anæsthetics it seems to me uncertain whether art gained, or general surgery lost, the more. At any rate, his apparatus for

evacuating stone after lithotripsy, is unquestionably the prototype of all modern evacuators, and in it lay the germ of the whole of modern lithotripsy. It is curious, in reading the early literature of this subject, to note how right Clover was in everything he taught and pointed out from the very beginning. Twelve years afterwards, when Professor Bigelow, of Boston, introduced his evacuating apparatus, it consisted of Clover's syringe with the receptacle of glass below, and the top connected with the evacuating catheter by a long flexible tube. Clover had taught and explained that the nearer the glass receptacle was to the penis the better, and after more experience Professor Bigelow accepted Clover's teaching and did away with all connecting tubing. Clover taught that the smaller the evacuating tubes the less water would they contain, and therefore the brisker the current within them. Bigelow's immense tubes have been found unnecessary and Clover's smaller ones employed. Clover's tubes were short; Bigelow's were long, and now all our tubes are as short as possible. Every one of Clover's tubes was fitted with that important adjunct, a flexible stylet. Bigelow's tubes had no such stylet, though he spoke of clearing his straight tubes with a rod, and now no lithotritist would use a tube without its being fitted with a flexible stylet, again showing how right Clover was. Clover's tubes had lateral plates or eyes at the distal ends. Bigelow's had not these lateral plates, which permit of the easy rotation of the tube when in the bladder and of the compression of the penis, rendering the route to the bladder all the shorter, now every operator uses these plates or rings. I think all this makes it quite clear that even Bigelow himself, and certainly all his followers, had to go back to Clover's principles, and for these principles, I assert, sufficient acknowledgment has never been made to our distinguished countryman. I believe Clover never operated for stone in his life; if he had been an operator it is more than likely that using his evacuator, and with the assistance of anæsthetics, he would have anticipated Professor Bigelow by twelve years, instead of that he handed his apparatus to Sir Henry Thompson, and contented himself with the administration of anæsthetics. At this time, 1866, Sir Henry Thompson was beginning to employ anæsthetics during his sittings of lithotripsy, but only in private practice.

In the hospital he still operated without chloroform, and in employing Clover's bottle there, he found that while the patient bore the introduction of the lithotrite in the crushing of the stone, with fortitude, he would often complain, and that bitterly, when the bladder was distended in the operation of evacuation. This led him to employ the evacuator without great enthusiasm, but when I joined him we took it to every operation and invariably employed it. Our practice then was nearly all in private, and the patients therefore always anæsthetised. In the autumn of 1878 Professor Bigelow proposed to treat calculi within the limits of lithotripsy by crushing and evacuating at one sitting. The principle was soon recognised to be of the very first importance, and it was accepted with remarkable openness and fairness of mind. I have done my work since 1878 acting upon Professor Bigelow's principle, but with my lithotrites and my evacuating tubes practically unchanged, but employing Professor Bigelow's improvement on Clover's bottle. The improvement in that instrument consisting in putting the rubber syringe above the glass receiver instead of horizontally beyond it, while at the same time I have taken away Bigelow's internal tube, reducing the interior of the tube to its original simplicity.

It has not been generally recognised that there are really three ways of removing a stone from the bladder. It may be removed by vesical incision

(lithotomy), it may be crushed and washed out (lithotripsy), and it may be washed out whole through a tube; and it is to this latter proceeding that I would confine the term litholapaxy, introduced by Bigelow to designate a procedure which is only lithotripsy on a large scale.

Litholapaxy, in my sense of the term, is the simplest and safest of the three methods, and if the stone or stones be small the operator should always attempt removal by means of tube and aspirator, and should only crush if the stone be too large to come through a No. 16, 17, or 18 (English scale) tube. Lithotripsy, that is to say Bigelow's lithotripsy, lithotripsy at a single sitting, is the operation for boys and girls, women and men, in all uncomplicated cases of stone in the bladder. The surgeon will be well advised if he subject his patient to lithotomy in all cases where he feels uncertain that he will be able to break and bring away every particle of stone at one single operation, for that is the essence of modern lithotripsy.

It is when faced with large stones in elderly and feeble men, and particularly when there has been long-standing prostatic or other obstructive disease that I think the modern lithotritist should pause. Supposing that the stone is not mechanically beyond the limits of the lithotrite, it must be remembered that the old man's urethra ill bears the repeated introduction of large lithotrites and tubes. The prostate may be so disturbed that no urine is passed afterwards except by catheter, and the mucous membrane of the bladder may be so injured that phosphatic deposits readily occur, and plague and torture the remaining years of life. In many of these cases the interests of the patient will often be best consulted by the removal of the stone through a supra-pubic vesical incision. Then there are many cases where it is impossible to thoroughly clear an old bladder from stone by instruments introduced through the natural passages owing to the presence of pouches or sacculi.

Then, too, the bladder itself in many of these cases is actually coated with phosphatic matter, which cannot be got away with the lithotrite. I would say, therefore, that if on examining an elderly man his urine is found to be clear and free from pus and the stone is felt to be of uric acid or of oxalate, and not large, say not over three ounces, it will probably be safe to perform lithotripsy. But if the urine is purulent and alkaline, the prostate very large, and the stone large and phosphatic, I think in most cases the best result will be attained by a supra-pubic lithotomy.

One of the old axioms in the art of lithotomy was that you should never cut for the stone, without having felt the stone with staff or sound immediately before making the incision, but even this valuable old rule has its exceptions. I remember a case in which, when ready to operate I was unable to touch the stone. In spite of that, a day or two later, I performed supra-pubic lithotomy, found an extraordinarily deep post-prostatic pouch, and at its bottom a stone measuring five inches in its largest circumference. The patient made a good recovery. It is the difficult cases that must be cut, and it is precisely the difficult cases where supra-pubic lithotomy is the operation. I look upon perineal lithotomy as obsolete. No finger is long enough to thoroughly explore the bladder through a perineal incision, and even if it be admitted that it is long enough to make a complete diagnosis, it is certainly not long enough to do any work in the bladder, to turn a stone out of a pouch, or to stretch and dilate the neck of such a pouch before getting out the stone. With reference to the return of stone after operation, I do not think statistics are important. It must be

remembered that after crushing or cutting the same constitutional conditions remain, and that the constitution may just as easily after one operation as the other form another stone. The same local conditions will also remain, so that if phosphatic calculus quickly follows the removal of a phosphatic stone by lithotripsy, it does not follow that lithotripsy is to blame. If, on the other hand, phosphatic calculus does quickly follow the removal of an acid stone by lithotripsy, it is very probable that either the vesical mucous membrane was injured, became inflamed, and offered a rough surface for the deposition of phosphates from the urine or that fragments and debris were left behind. If lithotripsy be undertaken it must be on the understanding that the operation must be completely finished, every particle of the stone must be removed. For this purpose it will be well to fragment and not to pulverise the stone. Pulverisation has been recommended, but this fine sand or mud is very difficult to entirely remove; it gets entangled in the mucous membrane and attracts phosphatic deposit, while fragments come away easily and are less likely to be left behind in the bladder. If a surgeon has been led by error in judgment to perform lithotripsy in a case not altogether suitable for the operation, and if he thinks he has unavoidably left some particles of stone behind, or indeed if he has the least suspicion that such may be the case, I advise that in four or five days after the operation, either with or without the aid of an anæsthetic, an evacuating tube be introduced and an aspirator applied. It will be found that particles, difficult to get away at the time of the operation, will have become loosened and will come away readily. It is often justifiable to undertake lithotripsy even when all the conditions favourable for lithotripsy are not present. The patient may be too feeble for the surgeon to think him fit to bear incision. In these cases a second or final sitting of lithotripsy, to ensure as far as possible the removal of every particle of stone, will be a wise proceeding. We thus see that in surgery, as in Nature, there are no hard and fast lines of demarcation, few absolute rules, and that the rule of modern lithotripsy to remove a stone at one operation has its wise and very proper exceptions. When the stone is very large I am altogether in favour of supra-pubic lithotomy. By this incision we have complete command of the bladder, there is little hæmorrhage, the stone is easily manipulated, and if necessary can be broken up and washed out. The delivery of a large stone supra-pubically is not always an easy proceeding. I do not like forceps, which are apt to project beyond the stone, and so unnecessarily tear the bladder. The best instrument is a scoop, placed well under the stone, while the stone itself is steadied by the operator's left forefinger. There are many forceps for breaking up a stone after the bladder has been opened by the knife, and there is no reason why Forbes Keith's giant lithotrite should not be used in this situation rather than from the perineum as practised by him.

India has for centuries offered an unrivalled field for the performance of stone operations, and there are surgeons there who can boast of such lists of cases that no surgeon in Europe or America can expect to equal. The remarkable results obtained in that country which indicate what I have elsewhere referred to as the tolerance of the Indian bladder must not be taken as our guide and model. To English surgeons this vesical tolerance in India is wonderful, we watch and we admire; but we must not be tempted to imitate. I am convinced that if we do we shall push lithotripsy to dangerous extremes, and bring it into discredit. Lithotomy will continue

to live—it has existed for thousands of years. It is the useful partner, not the jealous rival, of lithotripsy and litholapaxy.

## COMPLETE UTERINE PROLAPSE.

By FREDERICK HOLME WIGGIN, M.D.,

New York.

SOME recent editorial comments on the subject in THE MEDICAL PRESS AND CIRCULAR suggest to me that my experience of the treatment of "Complete Uterine Prolapse" may be of interest.

Of the various local, chronic diseases to which women are liable, complete uterine prolapse produces the greatest disability and discomfort. The condition is best described as a reducible hernia through the pelvic floor, the sac, which is the inverted vagina, containing besides the uterus, tubes and ovaries, a large portion of the small intestines, the bladder and the rectum.

The causation of the disorder, as is well known, is a primarily a separation—often submucous—of the tendons of the muscles forming the pelvic floor where they unite in the median line; this is usually due to the passage of the child during parturition. This separation of the tissues which hold the rectum in its proper position, allows the lower and anterior portion of the gut to bulge upward and forward into the vagina, pushing the vaginal tissues before it. This mal-position of the bowel is more or less increased by lifting heavy weights, but more particularly by every act of defæcation and straining at stool. As the muscular force expended follows the line of the least resistance it tends in these cases not to expel, as it should, the bowel contents through the anal opening, but to force the gut through the hernial opening into the vagina. The difficulty experienced by the sufferer in emptying the rectum causes her to exert an ever-increasing force, and gradually and steadily, day by day, the rectocele increases in size, and as it does so force is necessarily applied to the attached uterus in a downward direction. It also gradually begins to sag, and its ligaments, which in normal conditions serve simply as stays to hold it in place, are gradually stretched and lengthened by the weight of the descending organ upon them. The descending uterus must necessarily take the bladder with it.

The process is hastened, after it has fairly begun, by the added weight of the small intestines which, being contained largely in the pelvis, find their way by gravity to the lowest point. Thus, after a period of longer or shorter duration, varying usually in accordance with the natural vigour of the patient and the amount of work she is called upon to do by reason of her environment, a complete inversion of the vagina occurs, and a hernial sac of large size appears outside of the body, and we have the condition known as complete uterine prolapse to deal with.

This complete form of the disease does not, as a rule, appear until rather late in life, although the patient has suffered more or less discomfort for many years.

In the treatment of this disorder in its various stages gynecic surgeons have displayed much ingenuity and recommended various operations on the anterior and posterior vaginal walls, and have also advocated the radical operation of hysterectomy, but, unfortunately, without very satisfactory permanent results.

In the writer's opinion these disappointing results have been due to the failure to recognise the fact that the vaginal wall is practically a hernial sac with other contents than the uterus, tubes, and ovaries, and that consequently the simple repair of the ex-

ternal perineal body, the removal of the larger or smaller portion of the vaginal walls, or even removal of the uterus itself would not correct the greatest cause of the difficulty, namely, the mal-position of the small intestines.

In the patients who have come under the writer's observation, suffering from this disease, the uterus had not been abnormally enlarged, and consequently could not be considered as a factor in the causation of the trouble, and in many of these cases the tumour was of large dimensions.

In view of the foregoing facts the treatment required for the successful management of the class of cases under consideration evidently calls for an operation which will obliterate the hernial sac—or inverted and stretched vaginal wall—and a restoration of the damaged perineal structures as nearly as possible to their normal condition. The treatment, which has in the writer's experience, best answered these requirements has been as follows :

The patient on coming under observation is placed in bed in the recumbent posture and the tumour is reduced. Gravity is employed to help retain the parts in normal position by raising the foot of the bed about six inches. Tampons moistened with glycozone are also placed in position, and the parts are treated until all ulcerations on the vaginal walls are healed, the general condition of the patient during this time being carefully looked after.

The next step in the procedure is to perform a laparotomy on the patient after the usual preparations have been made, anæsthesia being produced by the use of ether or chloroform, or spinal cocainisation. Before the abdomen is opened the patient is placed in the Trendelenburg position for the purpose of getting the aid of gravity in drawing the bowels out of the way. They are usually found in these cases, more or less attached to the vaginal walls by adhesion, which must be broken up. The uterus, which has been previously stated, is in elderly women usually small, is found and pulled upward by the aid of bullet forceps, thus drawing the vaginal wall attached to it upward also. When this has been accomplished, a needle armed with kangaroo tendon is passed through the fibres of the uterus about the point of its attachment to the round ligament, and is carried up and down the broad ligament in the form of a purse-string suture, the needle being finally made to emerge about the point of entrance, so that when the two ends of the suture are drawn upon, the broad ligament on that side is folded up and drawn together so that excessive length is done away with, and the uterus has a new point of attachment near the insertion of this ligament at the pelvic brim. The same process is repeated on the opposite side, the abdomen flushed with saline solution, a quantity of which is left in, and the abdomen is closed rapidly in the usual manner. The patient is again placed in bed, the foot of which is slightly raised, and after the abdominal wound has healed the patient has usually recovered, four or five weeks later, she is again placed on the operating table and the separated tendons of the muscles are brought together with the submucous sutures of catgut or kangaroo tendon.

At the time of this second operation it will be found, if the first operation has been properly performed, that the redundant vaginal walls have practically disappeared, and the operator is in a position to find the separated tendons and can then easily bring them together.

The operation just described has been performed by me a considerable number of times on aged women, and it has been his experience that the operation is well borne by such patients because it can be

quickly performed in both of its stages, and does not involve any considerable loss of blood. The following cases serve to illustrate these statements:—

CASE I.—Mrs. M. L., æt. 73, was admitted to the Gynæcological Division of the New York City Hospital on April 25th, 1901, suffering from a complete uterine prolapse. The patient stated that an operation had been performed upon the anterior and posterior vaginal walls. This operation had evidently been a failure, since when she was seen by the writer an external tumour was present about six inches in diameter.

June 24th, 1901, after the patient was prepared in the usual manner  $\frac{1}{2}$  gr. of cocaine was injected into the spinal canal; this failing after half an hour to produce satisfactory anæsthesia, it became necessary to allow the patient to inhale a moderate quantity of ether; after a little while, however, it was apparent that the action of the cocaine was effective, and the administration of ether was discontinued during the rest of the operation. The abdomen having been opened, the operation of suturing the broad ligaments, as already described, was performed, the abdominal wound was closed and the patient returned to bed. Her convalescence was uneventful, and four weeks later the separated tendons of the perineal floor were found and brought together with buried sutures. The patient made a rapid and satisfactory recovery from the second operation, and when examined two months later seemed to be entirely cured of her difficulty, and was getting about with comfort.

CASE II.—Mrs. B. E., æt. 83, was admitted to the same service at the City Hospital, April 13th, 1901, suffering from complete uterine prolapse. She stated that when she was 38 years old she had given birth to one child. Ten years prior to admission she first noticed a prolapse of the vaginal wall, and within 18 months after that time the tumour had reached its full size, which was about five by six inches, notwithstanding the fact that she had been treated by means of various pessaries.

June 24th, 1901.—The patient was prepared in the usual manner and 1-6th gr. cocaine was injected into the spinal canal. In about twenty minutes the patient was sufficiently anæsthetised to permit the performance of a laparotomy, she having first been placed in the Trendelenburg posture, and the broad ligament and the redundant vaginal wall were sutured as described. On completion of the operation at 3 p.m., the patient was returned to bed suffering slightly from nausea and headache. These symptoms, however, soon disappeared and she was able three hours later to take and retain nourishment. Her convalescence was uneventful, and four weeks later perineorrhaphy was performed in the manner previously described. She was seen and examined two months later; her trouble had disappeared and she was able to walk about with reasonable comfort.

These cases, with many others which have come under the writer's observation, would seem to prove the statement that the abdominal operations not involving loss of blood and not requiring much time for their performance can be easily undertaken, if necessary, even though the patient is nearing the end of life.

Further experience with spinal cocainisation may demonstrate that it is particularly suited to this class of patients. If, as in cases just narrated, no injurious effects follow its administration, and the patients recover promptly from its use, being able to take and digest nourishment a few hours after the performance of a serious operation, the field of application of this procedure to elderly people will be very much widened.

THE Annual Meeting of Fellows and Members of the Royal College of Surgeons of England takes place to-morrow (Thursday) at 3 p.m. at the College. A copy of the agenda will be sent to any Fellow or Member on application.

## AN APOLOGY FOR BACTERIA. (a)

By R. TRAVERS SMITH, M.D., F.R.C.P.I.,

Assistant Physician to the Whitworth Hospital, Dublin.

AFTER some introductory remarks, the speaker said that it was necessary to dispel the popular belief that all bacteria and man were natural and deadly enemies. The belief resulted from the ceaseless attention which is drawn to the microbe origin of disease. In fact, bacteria, like man, are sufferers from the well-recognised phenomena of evil report ever outstripping good. A homely classification of bacteria might be made into (a) bad masters, the pathogenic; (b) good servants, other bacteria, an account of whose stewardship constituted the address. Bacteria were first considered in their rôle of scavengers. Were it not for those faithful toilers all dead animals and plants and the waste material of living ones would have remained as such on the surface of the earth, and would have accumulated till, by their very bulk, they had left no room for the living. Bacteria, by processes variously called decomposition, putrefaction, decay, and fermentation, are perpetually cleansing the world of its dead organic matter. Bacteria were next discussed in their most important function—namely, as purveyors of suitable food to plants. The vegetable kingdom extracts the necessary food for its growth from an originally limited stock of soil, air, and water. Did not Nature provide a method by which the material so used is restored to whence it came in a form again available as food for plants, vegetable life would become extinct from starvation, bankrupt from perpetually drawing on its capital. The extinction of the vegetable kingdom would soon be followed by that of the animal, since their interdependence is absolute. The food which plants take from air, soil, and water is, chemically speaking, very simple. In the plant body it is built into much more complex chemical bodies, starchy substances, albumens, fats, &c. These materials then feed animals, becoming more highly chemically complex in the animal body. It is obvious, then, that the sources of renewal of plants' food are three: dead plants, dead animals, and the excretions of living plants and animals; and that in order to be again available food to living plants, all three must be reduced from complex to simple form. This feat in analytical chemistry is performed by bacteria, which, while scavenging waste organic matter, converts it once more into suitable food for plants. Herein Nature has devised a wondrous and indispensable plan for economising her limited store of food by making it traverse a circle; first, leaving air, soil, and water, and passing to plants, thence to animals, to be brought back once more from the dead and from the waste products of the living to air, soil, and water, through the might of bacterial activity; without bacteria this circle would be incomplete, and the continuity of all life on the earth interrupted. Allusion was made to the ruthless waste of plant food caused by the prevalent systems of drainage. Instead of animal and vegetable waste being restored to the soil, it is swept into the sea. "Sewage farms" are a great step in the right direction. In this system of drainage the sewage is stored in tanks, where it is reduced to suitable food for plants by bacteria, and then thrown on the soil. The circulation of nitrogen round the food circle was considered more particularly to illustrate the essential and subtle part played by bacteria in Nature's scheme. Nitrogen exists in the dead bodies of animals and plants as proteids, albuminoids, &c., and in the excretions of living animals, chiefly as urea. Putrefactive bacteria convert the nitrogen thus stored up into ammonia and some free gaseous nitrogen. Other bacteria then oxidise this ammonia to nitrites, and others oxidise the nitrite to nitrates. In the form of nitrates nitrogen is absorbed by the roots of green plants in general, so, unless it can be rescued from the atmosphere in some way or other, the amount of nitrogen in the food circulation will be ever diminishing. Bacteria again saves the situation. Leguminous

plants, as peas, beans, &c., have on their rootlets little nodules, which are impregnated with bacteria. These bacteria have the power of fixing free atmospheric nitrogen, which they then unselfishly yield to the plant, especially to its seeds. Once back in a leguminous plant, the nitrogen, which was lost by putrefaction, has again entered the food circulation, and is devoured by animals in the form of peas, beans, &c. Mention was next made of the supposed port bacteria, which lay in the formation of soil and coal. A few of the more important industrial applications of bacteria were discussed. In the making of the best butter bacteria were indispensable. The value of butter mainly depends on its flavour and aroma. These were due to certain bacteria that flavoured the cream before it was churned. In the scientific manufacture of butter the cream is sterilised, so as to free it from all bacteria that might produce undesirable flavours; after this a pure culture of bacteria of known repute for producing excellence of flavour and aroma is added to the cream. By employing different bacteria, butter could be made of any particular flavour to suit any particular market with corresponding pecuniary advantages to the manufacturer. In a similar way the tastes of different cheeses were due to the action of different varieties of bacteria on fresh curd. In the manufacture of smoking tobacco from the tobacco plant, bacteria are essential. The crude leaves are subjected to various fermentative processes, for which bacteria are responsible. The particular species of organisms at work have been separated in pure culture. By judicious employment of such cultures the manufacturers can so modify the fermentation of the leaves as to produce desirable smells and flavours for the finished tobaccos. The "retting" of flax, whereby the linen fibres can be readily separated from the valueless portions of the plant, is accomplished by bacteria. No mechanical means has ever been discovered that can dispense with bacteria in the manufacture of linen from the flax plant. Time would not permit mention of any more industries in which, consciously or unconsciously, bacteria were employed. The list is a long one. The President concluded his remarks with a strong expression of opinion that these much-maligned microbes constituted a vital force, the full comprehension of which was still in its infancy. Prosperity awaits the country that scorns not to lavish time and money upon the cultivation, development, and utilisation of the lowliest of her subjects, the bacteria.

## Therapeutic Notes.

By GEORGE M. FOY, M.D., F.R.C.S.,

Surgeon to the Whitworth Hospital, Drumcondra, Dublin.

## DIONINE.

THIS ethyl-morphine derivative has been a sufficiently long time before the medical profession to allow of a fairly accurate opinion being formed of its therapeutic value. It is one of a group of new morphine derivatives to which benzyl-morphine and diacetyl-morphine belong. When von Mering, the discoverer, introduced it to the profession, through E. Merck, of Darmstadt, some few years ago, a description of the preparation appeared by me in THE MEDICAL PRESS AND CIRCULAR; since then the chemical has been submitted to the test of clinical experience both in France and Germany. So far the results have been most favourable, and have borne out the physiological experiments and fully justified the opinion that was formed of its action from its chemical formula. Indeed, the production of a salt such as dionine, the hydrochlorate of ethylmorphine, by the substitution of an organic radicle for one of its hydrogen components, points to a future in which existing alkaloids will be modified by the chemist so to meet the wants of the physician, that the latter will merely have to ask for a chemical to produce certain therapeutic effects, and it will be provided. Dionine possesses the sedative and analgesic effects of morphia, the alkaloid from which it is produced. But the preparation is not so powerful either as a narcotic or as an analgesic. It is, however

(a) Abstract of the Inaugural Address delivered before the University of Dublin Biological Association November 14th, 1901.

valuable in diseases of the respiratory system: pneumonia, bronchitis, tuberculosis, asthma and whooping-cough. In gynaecology dionine is, according to Bloch and Walther, indicated in painful periods, especially inflammatory dysmenorrhœa, also in painful inflammations of the pelvis, both of the parametrium and perimetrium, and also in malignant non-operable neoplasms of the uterus and its adnexes. Ophthalmologists employ it extensively on the Continent as a means of inducing lymph stasis in affections of the cornea and conjunctiva. To the general practitioner it will be found a valuable substitute for morphia in the treatment of pneumonia, its sedative effect on the respiratory centre not being so strong as that of the alkaloid; neither does it tend to dry up the secretions or interfere with the expulsion of mucus. For children it is a useful adjunct to the ordinary syrup and mucilage mixture for bronchitis. Asthmatic cases benefit greatly from its use; it seems to cut short the attack and to diminish the severity of the succeeding one. Both in the treatment of asthma and whooping-cough Dr. Rudolph Schmidt (*Ærst. Cent. Zeit.*), who has had a large clinical experience of the chemical, strongly recommends its use. In whooping cough he looks on it as a specific, and in asthma it has in his hands given better results than any other drug.

He holds the opinion that in dionine we possess a drug possessing the sleep-producing and pain-killing properties of morphia without any of those unpleasant after-effects with which all physicians are familiar. For alcoholism and acute delirium tremens the preparation on theoretical grounds should be well suited, as it neither depresses the heart nor injuriously affects respiration, and yet exerts a sedative effect on the cerebrum and cerebral nerves. It has the further advantage of being practically non-toxic.

#### SPANISH PRESCRIPTIONS.

##### TO CHECK VOMITING :

- R Hydrochlorate of cocaine, 0·05 grammes.
  - Menthol, 0·10 grammes.
  - Strong chloroform water, 75·00 grammes.
  - Distilled water of the aloe, 75·00 grammes.
- A teaspoonful every two hours.

##### ANEMIA (No. 1):

- R Precipitated sulphur, 10 grammes.
- Sugar of milk, 20 grammes.
- Ft. pulvis.

A small quantity to be taken at the beginning of each meal.

##### (No. 2):

- R Powdered digitalis leaves, 2 grammes.
- Lactate of iron, 2 grammes.
- Extract of gentian, a sufficiency to make thirty pills, of which two are to be taken daily.

##### INSOMNIA :

- R Extract of belladonna, 0·25 grammes.
  - Extract of cannabis indica, 0·25 grammes.
  - Bromide of sodium, 15·0 grammes.
  - Hydrate of chloral, 15·0 grammes.
  - Simple syrup, 100·0 grammes.
- One or two tablespoonfuls during the night.

##### HÆMOSTATIC PILLS :

- R Extract of hydrastis canadensis, 0·02 grammes.
- Extract of hamamelis virginica, 0·02 grammes.
- Ergotine, 10·0 grammes.
- Damien, a sufficiency to make a pill.

One every four hours.

##### HEMICRANIA :

- R Antipyrine, 0·50 grammes.
- Bromide of potassium, 0·50 grammes.
- Hydrochlorate of cocaine, 0·01 grammes.
- Caffeine, 0·02 grammes.
- Powdered Paullinia sorb., 0·60 grammes.

Make a powder.

*El Siglio Médico.*

MR. C. B. BALL, Regius Professor of Surgery in the University of Dublin, has been offered a seat on the Advisory Board to be established under the scheme for the reorganisation of the Army Medical Service.

## Transactions of Societies.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.  
MEETING HELD WEDNESDAY, NOVEMBER 6TH, 1901.

Mr. A. G. MILLER, President, in the Chair.

DR. MELVILLE DUNLOP showed a case of chloroma. The subject of this extremely rare disease was a boy, æt. 6, and the symptoms had not lasted for many weeks. The patient was admitted to hospital with signs of anæmia and slight fulness about the eye, and the blood count showed a leucocytosis amounting to 24,000 leucocytes. The leucocyte count had gone steadily up, reaching 61,000, and with this there had been progressive weakness, and development of the characteristic facies. There was marked proptosis, caused by retroocular lymphoid growths, which could be felt above and below the eyeballs, there was also a considerable amount of lymphoid deposit about the malar region, and latterly two swellings had appeared on the palate. The condition was extremely rare, and this was a very typical case of the disease.

DR. NORMAN WALKER showed three cases of lupus. One of these had been under treatment by exposure to the Röntgen rays for several months, and now the condition was, for the time being at least, cured. As a result of the X-rays there had been a very marked reaction, the cheek had become inflamed, and an ulcer had formed, but notwithstanding this the treatment had been persevered in, and the ulcer had healed very rapidly. There was no doubt that these rays exercised a markedly stimulating effect on the growth of epithelial tissues. That could be seen in this case, where the cutaneous epithelium had actually grown over the conjunctival mucous membrane at a spot where the lupus had caused ectropion. The second patient suffered from multiple lupus. One patch, about ten inches in diameter, on the buttock, had been treated successfully by excision and skin grafting; a second, on the arm, had been extirpated by the galvano-cuttery; a third, on the face, was being subjected to the X-rays, while a fourth had healed spontaneously. The third patient was being treated by the X-rays, and had improved considerably. Dr. Walker exhibited a Finsen's apparatus and explained that if the hand was pressed against the bull's-eye lens it became quite translucent, except for the blood-vessels, through which the rays of light did not penetrate. In using the light, therefore, it was necessary to press the glass firmly against the affected tissues, so as to render them anæmic, otherwise the rays did not penetrate the parts.

MR. STILES showed (1) a girl after operation for plexiform angioma of the scalp. The difficulty in such cases was to control hæmorrhage, and, as the dilated arteries had extremely thin walls, and sprang from vessels embedded in the firm tissues of the scalp, it was impossible to ligature them in the ordinary way. He had, therefore, made a transverse incision through the scalp over every artery which entered the angioma, so as to divide the vessel completely. The vessels were then ligatured by passing catgut under their divided ends with a fine needle. The process of knotting the ligature caused the edges of the small wounds to approximate, and no stitches were required. Altogether twelve arteries were dealt with in this manner, and electrolysis was performed about ten days later. The condition was much improved, and it was now proposed to excise the mass, which could be done without much risk from bleeding. (2) Skiagrams from a case of congenital dislocation of the hip in a patient, aged one year and nine months. This was the youngest case he had seen, and the diagnosis had been a matter of some difficulty. Relying on the fact that the limb could be adducted more readily than its fellow—it could be crossed over the upper third of the opposite thigh, whereas normally it should not cross higher than the lower third, and that doing so made the head unusually prominent, as well as on the fact that the degree of possible abduction was diminished, Mr. Stiles concluded that this must be a case of congenital dislocation, and the skiagram confirmed

his opinion. (3) A child after operation for tuberculous disease of the frontal bone. (4) The calvarium of a child who had suffered from multiple tuberculous osteomyelitis of the cranium. (5) Darning-needle removed from the abdomen of a child. (6) Sac of a hydrocele, with constriction corresponding to the external abdominal ring. (7) A hernial sac and strangulated testicle removed from an infant fourteen days old, during operation for irreducible inguinal hernia. The swelling had been present for forty-eight hours when the child arrived in hospital, and faecal vomiting had set in. On opening the sac the bowel was found to be glossy, and could be returned without difficulty. The strangulated testicle was then found, the strangulation being apparently due either to direct pressure of the knuckle of bowel, or to torsion of the cord caused by the presence of the bowel in the scrotum.

Mr. ALEXIS THOMSON showed a sarcoma of the small intestine, causing incomplete obstruction.

Dr. HARVEY LITTLEJOHN showed specimens of (1) extra-peritoneal rupture of the bladder following a kick on the abdomen, and (2) enormous dilatation of the pulmonary artery, the vessel measuring six inches in circumference. The heart was hypertrophied, the left lung completely fibroid and airless, the left branch of the pulmonary artery was occluded, while the right admitted three fingers easily.

Dr. ALEXANDER BRUCE read a paper

ON THE MOTOR LOCALISATION IN THE LUMBO-SACRAL REGION OF THE CORD.

As a preliminary to the study of the subject it was pointed out that (as Dr. Bruce's researches had shown), the arrangement of the groups of nerve cells on the grey matter of the cord is constant in different persons, and that it is possible by examining any section to say to which segment it belongs. Secondly, there is a constant reaction on the part of nerve cells where motor nerves have been divided, as has been described by Nissl and Marinesco. The nuclei of the cells become lateral instead of being central, the Nissl bodies disappear, and the whole cell assumes a granular appearance. These changes develop constantly after fourteen days have elapsed since the section of a motor nerve. It is thus possible to make out the motor centre of a muscle by observing the degenerative changes which ensue upon its removal. Dr. Bruce's material consisted of two cords, one from a case of amputation just above the knee-joint; a second from a case where the whole leg and the greater part of the ilium had been amputated. In the normal lumbo-sacral cord the following groups of cells could be distinguished: (1) Antero-lateral group, extending down to the second sacral segment, and attaining its maximum size at the first sacral; (2) postero-lateral, which increases in size downwards to the first, and ends in the third sacral; (3) a post-postero-lateral in the first, second, and third sacral; (4) a central group, extending down to the third sacral; (5) a mesial group, which disappeared at the fourth lumbar, and reappeared at the third sacral. Sections of the cord of the first case, in which all the nerves going to the muscles of the leg below the knee and the small muscles of the foot had been divided, showed a degeneration of the cells of the postero-lateral group in the segments from the fifth lumbar to the third sacral, as well as of those of the post-postero-lateral group in the first three sacral segments; the antero-lateral, mesial, and central groups escaping. A case of van Gehuchten's practically agreed with this one of Dr. Bruce's. The speaker's second case was one in which all the muscles of the leg had been removed except the psoas and iliacus, the obturator internus, the pectineus, the pyriformis, and the two gemelli. In the sections of this cord the antero-lateral and postero-lateral groups were partially degenerated in the second and third lumbar segments, the undegenerated cells probably representing the centre for the psoas and iliacus. All the cells were degenerated in the fourth lumbar, while in the first and second sacral a few undegenerated cells were present in the antero-lateral group only. These apparently represented the centres for the pyriformis, obturator internus, and gemelli. From these two

cases it seemed that the thigh muscles had their centres in the antero-lateral group from the second lumbar to the second sacral and in the postero-lateral group above the fifth lumbar, while the centres for the calf and leg muscles were in the postero-lateral group from the fifth lumbar to the third sacral, and those for the foot muscles in the post-postero-lateral group. There was reason to suppose that the pudic nerve was injured at the operation, and degenerated cells were found in the mesial group of the third and fourth sacral segments. This mesial group of cells has a curious distribution; it disappears in the upper sacral and lower lumbar regions, is well developed in the dorsal region, and again vanishes in the cervical enlargement. There is reason to believe that it contains the centres for the muscles of the trunk, and the degeneration of cells with injury to the pudic nerve was of interest in this connection.

Dr. BRYON BRAMWELL congratulated Dr. Bruce, and Dr. PATON remarked that whereas the cortical centres represented physiological movements rather than individual muscles, this did not seem to be so in the cord.

Dr. DAVID WATERSTON described the grouping of the nerve cells in the lumbo-sacral cord of the cetacea. There the lower limbs were rudimentary, while the perineal muscles were enormously developed. He had found that the antero-lateral and postero-lateral groups were insignificant, while the median group was largely developed.

Dr. BRUCE, in reply, said that the arrangement of these centres was not what he had expected. He had thought that they would be grouped together so as to represent movements. Apparently this was not so, and one found that individual muscle, rather than combinations of them, had special centres. His observation explained how one saw infantile paralysis begin in the foot and suddenly spread to the buttock. The two sets of muscles were close together in the cord, not several segments apart, and a lateral spread of the poliomyelitis, not a vertical one, was all that was required to explain such a case.

The retiring President, Mr. A. G. MILLER, then delivered a valedictory address, in which he shortly reviewed the work of the past two years, and congratulated the Society on its increasing membership and the greater interest which members were taking in its proceedings. Two foreign members had died during the year, one extraordinary member, and nine ordinary members; to these appropriate allusion was made.

The following office bearers were elected for the ensuing year:—President, Dr. T. R. FRASER; Vice-President, Dr. James Ritchie; Council, Mr. A. G. MILLER, Drs. Paton, Russell, Logan Turner, Ballantyne, Kerr, Douglas, and Mr. Stiles; Treasurer, Dr. Harvey Littlejohn; Secretaries, Dr. Melville Dunlop and Mr. Alexis Thomson; Editor of Transactions, Dr. Craig.

ROYAL ACADEMY OF MEDICINE IN IRELAND.  
SURGICAL SECTION.

THE Opening Address was delivered on Friday evening, the 8th inst. by Mr. THOMAS MYLES, President of the Royal College of Surgeons, President of the Section.

Mr. MYLES took for his subject the advantages of operative interference in complicated fractures of the long bones, as practised by Mr. Arbuthnot Lane in London. He compared the surgical audacity of operative measures on the abdominal contents, and the timidity which surgeons exhibited in the more accessible regions of the upper and lower extremities in cases of fracture. The older classifications of fractures were, he considered, too artificial to be helpful, and were, to the beginner, stumbling-blocks to diagnosis. Cases of fracture complicated with dislocation were difficult of diagnosis, and where, as was sometimes the case, calcareous deposits formed, the Röntgen rays gave little aid. He met one such case in which a fracture of the anatomical neck of the humerus was complicated with dislocation of the head of the bone, and the deposition of a large calcareous mass which extended up to the clavicular articulation. All the classic symptoms of separation of the greater



tuberosity were present, and the pathological condition was only made known by raising the deltoid muscle. In such doubtful cases he recommends that the deltoid be separated from its brachial insertion, and the part exposed so that the lesion may be recognised. The operation presents no difficulties, is quickly performed, and is comparatively free from risk.

#### LAPAROTOMY FOR INTESTINAL OBSTRUCTION.

Mr. LENTAIGNE read a paper on a case in which laparotomy had been twice performed, with six months interval, for the relief of intestinal obstruction, resulting from the presence of large concretions in the colon. The patient, a boy commencing his teens, had been addicted to chewing woollen fabrics, blankets, and such like, and when admitted to hospital was suffering from constipation and vomiting, which daily became worse. For a week he got injections through an O'Beirne's tube, which were unattended with any good results. An operation was performed. The abdomen was opened, a large concretion removed from the colon, and the boy made a good recovery. Six months afterwards he was again admitted to hospital, and again after a fair trial of injections a laparotomy was performed and the colon opened and evacuated, in the performance of which the old silk continuous sutures of the previous operation were come on and found to have remained unimpaired. An attempt was made to create a fistula in order to prevent the recurrence of the condition. The fistula, however, closed, and the boy, now convalescent, left hospital, to return some time afterwards with the same symptoms—vomiting and constipation. A finger in the rectum now detected a large concretion, which was in part scooped out and washed out. The boy made a good recovery; has discontinued the pernicious habit, and remains well.

Mr. MYLES considered the paper very instructive, as showing the difficulty of diagnosing abdominal tumours, and said that in a somewhat similar case he had seen good results obtained from olive oil injections, followed by the use of electricity, which produced free vomiting and purging.

Mr. CROLY thought palliative treatment by injections might have been given a more extended trial before resorting to colotomy. He thought the second operation unnecessary, and there was nothing to indicate that it had been advantageous.

Mr. McAEDLE quite agreed with Mr. Lentaigne in the necessity for early operation in such cases; nothing was gained by delay, and it was sound surgery to operate and remove the concretion from above. He was particularly pleased with the fulness of detail with which the paper was presented.

Mr. MITCHELL (Belfast) congratulated the author of the paper on finding an hypertrophied colon. In one of his cases the colon was so much attenuated that the tissue could not hold the sutures, the wound opened, and the boy died.

Mr. ORMSBY gave an instance of a patient of his who ate her hair, nibbling off portions until she produced a mass of matted hair in her stomach, which he excised.

Mr. DOYLE drew attention to the tendency of alimentary concretions to simulate malignant disease of the bladder. A patient of his, treated for malignant growth of the bladder, was found after death to have a healthy bladder, the trouble having been caused by an immense accumulation of charcoal in the rectum and descending colon.

Mr. CHANCE instanced the case of a boy, who, from eating straw, formed a mass in his ileum about the size of a banana, which necessitated operation.

Mr. LENTAIGNE, in reply, thought that any further use of palliative remedies would have done away with all prospect of success. The second operation was not attended with any benefit, but having performed it he thought it but right to mention it.

Mr. H. GRAY CROLY showed (a) child, *æt.* 4, showing results of excision of astragalus for tuberculosis; (b) child, *æt.* 7, showing results of excision of astragalus and end of fibula, with gouging of os calcis for tuberculosis; and the astragalus removed from three patients.

Mr. E. H. TAYLOR showed (a) patient in whom the so-

called excision of the superior maxilla has recently been performed for sarcomatous disease; (b) cases showing the result of operation for complete cleft of the hard and soft palate (own operation); (c) case presenting extensive varicosity of the veins of the right upper extremity. He also exhibited (a) parts removed in the operation of supra-pubic prostatectomy; (b) kidney removed for calculous disease; (c) sarcoma of superior maxilla; (d) comminuted fracture of the atlas vertebra the result of a fall.

The meeting then adjourned.

#### LIVERPOOL MEDICAL INSTITUTION.

FIRST ORDINARY MEETING OF THE SESSION HELD OCTOBER 20TH, 1901.

The President, Mr. EDGAR A. BROWNE, in the Chair.

#### CASE OF ANEURISMAL VARIX OF FEMORAL ARTERY.

Mr. E. C. DUN showed a patient suffering from aneurismal varix of the femoral artery and vein in the upper part of Scarpa's triangle on the left side resulting from a Mauser bullet wound. Very severe hæmorrhage had immediately followed the receipt of the injury. The communication between the artery and vein had apparently developed on the third day after the wound was inflicted, as indicated by the super-venition of pulsation and thrill over the vessels. For the past year the patient had been doing full work as a tailor, suffering comparatively little inconvenience. There was no distinct tumour in Scarpa's triangle, merely an ill-defined swelling. Expansive pulsation and marked thrill were present, with a very loud rumbling bruit resembling the noise heard when travelling in a train passing through a tunnel. There was no œdema of the limb, below, or varicosity of veins. The pulsation and thrill gave no inconvenience to the patient after long standing or walking, and the limb was readily tired. It was not considered advisable to attempt any operative interference.

Mr. RUSHTON PARKER referred to a formidable case of the kind operated on by Professor Lister in Edinburgh, over twenty years ago. The femoral artery was tied above and below the aperture, and the much dilated vein was stitched up with antiseptic catgut, and its channel preserved. Though much blood was lost in a prolonged operation, the patient recovered with a useful limb.

#### RING STRICTURE OF THE SIGMOID FLEXURE.

Mr. GEORGE HAMILTON mentioned several cases of ring stricture of the sigmoid flexure, which he had previously brought before the Society, and which were still alive and well. Stress was laid first on the fact that carcinoma of the intestine was not nearly such a malignant disease as carcinoma elsewhere; secondly, that an operation for removal was best conducted in two stages, no attempt being made to unite the divided bowel at the primary operation. A very unusual case was related of a schoolmaster who was *æt.* 68, and who suffered from a carcinoma of the sigmoid flexure, which had become (owing to a long me-cocolon) attached to about the middle of the transverse colon. In order to remove this growth it was found necessary to take away sixteen inches of large bowel. The man had made an admirable recovery. Mr. Hamilton made some further remarks on the advisability of recognising these ring strictures before much intestinal obstruction occurred.

Mr. RUSHTON PARKER agreed with Mr. Hamilton that in cases of this kind it was the best practice to tie tubes in the cut ends of the gut and bring them out of the wound, reserving to a future operation any attempt that might be made to reunite the gut.

Sir DYCE DUCKWORTH read a suggestive paper on

#### THE PERSONAL FACTOR IN TUBERCULOSIS,

an abstract of which will be found in another column. In the discussion that followed

Dr. T. E. GLYNN considered that Sir Dyce Duckworth's remarks on the importance of recognising the part played by the constitution of the host in the

development of tuberculosis were fully warranted, owing to the attitude of certain physicians at the present time. He had the opportunity of seeing a number of medical reports on the health of applicants for insurance, and had noted that some medical examiners, in cases where there was a history of phthisis in a family, made such remarks as this:—"Some of the relatives have died of tuberculosis, but this affection is no longer considered hereditary, and it is not necessary to charge an extra." The pathologist in his inoculation experiments studied only one aspect in the aetiology of tuberculosis, but he could not understand how the physician could fail to recognise the importance of the other aspect—predisposition, hereditary or acquired. He thought that for the most part what was formerly known as the strumous diathesis would now be recognised as degeneracy.

Dr. W. CARTER agreed that it was as necessary to consider the soil as the seed, but he believed that most, if not all medical men, took this view. Facts bearing on the importance of the nature of the soil were too patent to be mistaken, such, for example, as tuberculosis coming after small-pox, &c., the different order in which structures were attacked in the young as compared with the aged, the greater degree of susceptibility of the coloured races, &c. In every case it seems to be a struggle between destructive and defensive forces, for the probability is that there is no absolute immunity in any individual of any race. It seems probable, also, that the bacillus tuberculosis can grow on different media and produce different toxins accordingly.

Dr. WARRINGTON recognised the greater vulnerability of some to tuberculous disease, arising either from inherited defects or acquired conditions of lowered vitality. He considered, however, that it must be a very difficult task to point out such *specific features* in individual physiognomy as would enable an observer to state with reasonable probability which individuals were more liable to tuberculosis. Similarly he considered it would be difficult to predict of several individuals, previously healthy and whose family history was unknown, which individual was, on exposure to cold and fatigue, most liable to rheumatic fever. The pneumonia bacillus inhabiting the mouth of a healthy person might be as virulent as that found in one suffering from the disease. There must, therefore, have been some change in the host, but this change could not be recognised. The statement he would emphasise is that the proof of a diathesis is often the proof of a disease.

Dr. THOMAS HARRIS (Manchester) scarcely thought that the modern pathologists so completely ignored the general equation of the suitability of soil in favouring or retarding the development of tuberculosis, as the author of the paper inferred. There could be no reasonable doubt that the suitability or otherwise of the soil not only affected the tendency to the development of tuberculous foci in the first instance, but also played a great part in the subsequent progress of such foci. The favourable results following the modern treatment of tuberculosis in open-air sanatoria were doubtless due to the rendering of the human organism a less suitable soil for the progress of the lesion, and resulted in many cases in an arrest of the disease; it was quite right to use the term "arrest" in reference to such cases, and to avoid the term "cured."

Drs. Buchanan and Barr also spoke, and Sir DYCE DUCKWORTH replied.

## Department of Lunacy.

### LUNACY IN FORFARSHIRE.

At a meeting of the managers of Montrose Asylum, held on the 6th inst., it was reported that Dr. Fraser, Commissioner in Lunacy, who lately visited the asylum, said in his report it would be evident that the provision of additional female accommodation was urgently required, and he understood with satisfaction that they had resolved to erect a villa for females. It was hoped that there would be no further delay in providing this extension. The dayroom accommodation for females in

the hospital was overcrowded, but adequate dormitory space was obtained by utilising rooms originally intended for the hospital staff. The margin of spare accommodation for male pauper patients throughout the asylum was small, and it would be obvious that the erection of a villa for sixty females would not wholly relieve the overcrowding in the female sections which at present existed. The Commissioner had also congratulated them on the way in which the asylum was being conducted, for which they had to thank Dr. Havelock and the other officials. It was the intention to build a house to accommodate sixty patients, but it is manifest that a house of that size would not even meet the present requirements, and therefore, provision for about 100 patients would have to be made. However, discussion on the subject was delayed. Dr. Fraser's report was considered a thorough one.

### TYPHOID AT MORPETH ASYLUM.

It was reported by the Committee of Visitors of Morpeth Asylum at a quarterly meeting of the Northumberland County Council, held at Newcastle on the 7th inst., that there had been a serious outbreak of typhoid fever at the asylum and in the cottages. In all, fifteen persons had been affected, and the Committee regretted to say four of the patients had died. The Medical Superintendent attributed the outbreak to the introduction of the disease from without, through the medium of flies, which is a very likely hypothesis. A serious neglect in the want of an isolation hospital has given rise to the spread of the outbreak. The nurses were said to lie in touch with each other, and the patients were lying near one another. If this statement be correct, things look indeed very serious, and we are amazed that the attacks were limited to the few reported.

## France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, November 17th, 1901.

### TYPHOID IN PARIS.

THE typhoid fever epidemic in the north-east part of Paris is spreading to an alarming extent. Over 100 patients were admitted to hospital on one day last week. Several nurses have been attacked with the disease, and two have died. Eighteen cases have occurred among the soldiers quartered in the Tourelles Barracks. The epidemic is attributed to contaminated water supply.

### NO MENTONE FOR THE PHTHISICAL.

Mentone has hitherto been looked upon as *par excellence* the resort for consumptives, but the hotel proprietors of that town are apparently of opinion that their presence is prejudicial to the higher interests of this delightful spot in that it tends to scare away the healthy and wealthy whose patronage they would prefer. This is the inference which is to be drawn from the resolution recently passed by the hotel proprietors in solemn conclave assembled, but they had better have a care, since one of the first results would probably be the construction of sanatoria specially destined for the reception of phthisical patients.

### DAMAGES FOR PREMATURE BURIAL.

A sensational case has just been tried in France, at least so it is reported, in which 200,000 francs damages were awarded to the father of a lady who arrived in France from Senegal, suffering from yellow fever, who died, as was believed, and was buried, but on the body being exhumed the deceased was found to have given birth to a child in the coffin, whereupon it was assumed that she had been buried alive. The Court apparently endorsed this view, and gave heavy damages against the

certifying doctor and the Government. It is hardly necessary to point out to medical readers that posthumous delivery by no means justifies the assumption of premature burial. The contraction of the muscles in *rigo-mortis* will explain the expulsion of the infant; indeed, we believe that instances of the kind are on record. Nevertheless, the occurrence is one which may well be held to tell against the practice of prompt inhumation which obtains in some countries, France among the number.

### Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, November 16th, 1901.

#### VAGINAL PUNCTURE AND INCISION.

HR. H. FRANZ, of the Royal University Klinik for Women's Diseases, Halle, has a paper on this subject in the *Munch. Med. Woch.*, 31/1901. Vaginal puncture is, he says, first of all a welcome aid in diagnosis in the case of tumours lying in Douglas's pouch. It is also serviceable in the diagnosis of tubal swellings whether they be of inflammatory nature or resulting from tubal gravidity and in exudative peritonitis.

It is also of therapeutical importance in dealing with growths in the posterior pelvic region. Twenty cases of this kind were completely removed by incision, eleven improved, two remained in the same condition, and two died. By far the best results were obtained in cases of simple abscess in Douglas's pouch, whether the result of infection after operation or from inflammation near the cæcum. These cases all recovered. The reason of this good result is clear. The abscess cavity being opened and drained recovery must of necessity follow if there are no further sources of infection. It is different when tubo-ovarian tumours are incised. Complete recovery rarely takes place here by simple incision. The inflamed ovaries and tubes being left readily give rise to fresh inflammation. Still more unfavourable is simple incision for hæmatocele from extra-uterine gravidity. Here it is only justifiable when the collection has become fœtid or septic, and operation by the abdomen is unusually dangerous owing to the septic condition present.

Puncture is made at the lowest fluctuating part of the swelling. If the contents of the cavity escape through the tube the cervix is seized with a pair of forceps and pushed forwards and upwards. By this means the vaginal mucous membrane is made tense round the trocar, and the opening can be readily enlarged with a knife. A pair of forceps can then be passed in and the opening enlarged by separating the blades of the forceps. When the contents have escaped a rubber drainage-tube can be inserted and the remainder of the cavity packed with iodoform gauze. The drain must, of course, be kept clear. Cases generally recovered in from two to three weeks.

At the first meeting of the Medical Society Hr. V. Bergmann gave an address on

#### AMPUTATION IN PHEGMOSES.

He recalled Virchow's work on life in the blood, wherein it was shown that the blood was not for long the carrier of foreign bodies. The view often held that the life of the patient was lost so soon as deleterious

material circulated in the blood was erroneous. A proof of this was shown by many cases observed in the Klinik. In phlegmosis the process of disturbance was plainly shown clinically. We were not powerless as regarded the advance of the process. Appropriate incisions of the skin, the connective tissue, the fasciæ, and the tendon sheaths had given extraordinarily good results, as he had shown in a previous address. If the blood were examined in such cases micro-organisms were found which were looked upon as exciters of disease, streptococci, staphylococci, &c.; proof could be furnished by cultivation in animals or upon agar. If deep incisions were not enough to evacuate the pus which formed early in the sheath of the tendons, and did not relieve, the question arose whether removal of the affected limb would not be of service. On many sides the question had been answered in the negative, and it had been held to be very dangerous to remove limbs when micro-organisms were already circulating in the blood. Dörfler, of Regensburg, had characterised such operations as surgical heresies, against which the State authorities ought to bestir themselves. Whilst this author was in such extreme horror of such amputations, he, the speaker, as urgently counselled them. The question as to the best time when such amputation should be undertaken was when incisions did no more good, when, therefore, in spite of wide openings the phlegmon extended further and farther, when, in other cases, the result had been favourable, then was the time to carry out the amputation. His assistant, Wolff, had much interested himself with the question, and of six cases of spreading phlegmon in which amputation had been successful in saving life, in five of them micro-organisms had been shown to have been present in large quantities in the blood, as proved by inoculation and cultivation. He mentioned as especially convincing the case of a student, æt. 20, who was admitted into the Klinik on September 27th last, who had been so unfortunate in springing from a street car as to crush the greater part of the hand. The conservative treatment at first tried failed. Even on September 29th the little finger of the left hand had to be removed, but the phlegmon rapidly advanced. Further examination of the blood from the wound and from the right median vein gave a positive result—streptococci were found which killed mice inoculated with them.

Extensive incisions were now made on the back of the forearm, the swollen arm was incised, on October 3rd the wrist-joint, which already contained pus, was opened. The fever did not subside, however. The patient became delirious and exhibited the other signs of grave septic disturbance, and the number of micro-organisms circulating in the blood increased. On the evening of the same day on which the extensive openings had been made amputation was performed. Examinations of the blood were made twice on that day, and the result was interesting. At first large numbers of micro-organisms were still found in the blood, but the number gradually diminished, and in a few days they had quite disappeared. An inoculation made on October 11th was without result, whilst streptococci were still present in the pus from the wound. They disappeared from that also, and the wound granulated, and was now soundly healed. The speaker was therefore unconditionally in favour of amputation in such cases at the stage mentioned.

## Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, November 16th, 1901.

## BIER'S CONGESTION ON THE DEVELOPMENT OF BONE CALLUS.

At the "Gesellschaft" Bum gave the Society an account of his results in a series of experiments conducted at the "Wiener Universität" under Professor Paltauf, and with the assistance of Professor Biedl.

The object of the experiments on animals was to prove to their own satisfaction the correctness or incorrectness of Bier's theory of venous congestion, or "stauungs-hyperæmie," having any practical value in local tuberculosis. A close examination of the morbid changes that take place in these animals when under experiment positively proves the complications that obscure any attempts at elucidation. The results, however, are somewhat satisfactory, and plainly demonstrate that the influences in operation that cause the increase of tissue must be of an anti-parasitic nature, and that the inflammation is an aseptic one. It is the physiological change that takes place in the repair of fractured bone or cartilage.

Since the days of Dumreicher, similar empirical practices have been carried out by bandages to consolidate pseudoarthrosis, while Nicoladini aimed at nutritive irritation of the tissues, which produced a hyperæmia.

Bum's experiments were first conducted on guinea pigs, and later on dogs. The tibiae were diaphysially fractured and "gypsum" bandages applied. The right and left were symmetrically broken, so that observations could be compared on each leg. The right leg was daily congested for one or two hours just above the knee-joint. Some of the animals died while others were killed. On the congested side this imbibition of serous fluid was extensive in the subcutaneous intermuscular fibrous tissue of the peripheral parts with great increase of callus and restriction of bone union. He showed sections which demonstrated extensive calcification and ossification of the periosteal callus.

## ONYCHOGRAPH.

Castagna showed an apparatus to the Society for registering the pulse at the nails, which is termed an "Onychograph." It is composed of a metal knob which lies on the finger nail and records the pulsation through a lever on a rotating drum.

## GLANDULAR FEVER.

At "Doctoren Collegium" Hochsinger brought the subject of glandular fever before the meeting. This term, he said, was first introduced by Pfeiffer, of Wiesbaden, in 1889, it preferably attacks children between five and eight years of age, resembling infectious diseases, having pain in the glands which often went on to suppuration, but in the greater number of cases ended in spontaneous resolution. The glands attacked were the cervical and submaxillary with knots in the lymphatics. The attack was usually ushered in with general malaise, pain in the limbs with restlessness,

The tongue was red and coated, but fauces clean; pain in throat when swallowing, as well as in active and passive movement, the patient often holding the

head as in torticollis. In severe cases there were often hoarseness and running at nose, enlargement of spleen and liver, with severe pain in the middle line of abdomen between umbilicus and symphysis, associated with nephritis.

Hochsinger gave a number of examples having no connection with tubercle or syphilis, and occurring among young children, commencing with a number of irritative inflammatory points in the skin, mucous membrane, as well as the head and face.

Another type of these form glandular swellings in the throat, and others after acute infectious diseases, without any rise of temperature, which are often slow and persistent. There is yet a third type of this disease, occurring after acute specific fevers, in which the mouth, nose, and throat become involved, with a high range of temperature and large gland.

Hochsinger was inclined to believe these glandular fevers were secondary, as Manfredi had so ably supported by showing the presence of virulent microorganisms in the diseased glands, which had probably re-infected the organ. The disease might be termed a local glandular inflammation, and not idiopathic as some would have us believe. There is no uniformity in either the ætiology or clinical symptoms. It may first be considered as a deposit in the retropharyngeal tissues, and subsequently forming an abscess. Hochsinger affirms that he has often seen the fever preceded by a reddening of the hard palate, resembling the infection of Luschka's tonsils, which raises the question of a preceding pharyngitis or tonsillitis. The low resistance of the adenoid rings in the throat at this tender age may be advanced as a cause of the disease; but more probably the true cause may be a previous catarrh, tonsilla pharyngea, or lymphadenitis febrilis cervicalis. Another gives it as a previous inflammation of Luschka's tonsils by an infectious toxin like influenza, &c.

The theoretical objection to "gland fever" is the probability of its being scrofulous.

The treatment adopted by Hochsinger is either a lotion of the acetate of alum, or Goulard water applied to the glands. After the fever has subsided he prescribes an ointment of ichthyol, &c. The prophylaxis presided in treatment of the laryngeal glands, but he dreaded the name of gargle. Pastilles and such like, impregnated with the prescribed drug, were beneficial and frequently very powerful disinfectants.

Weil wondered at Hochsinger's objection to a gargle, as he considered a 5 per cent. solution of creosote a very powerful antidote in the nares and pharynx. Another excellent mode of treatment was by insufflation with sodium soziodolicum, which can be easily performed in the case of children.

Pinus was of opinion that all hyperplasia of the lymphatic glands was a secondary phenomenon. This was indubitably manifested in scrofular inflamed gland. The best prophylactic, to his mind, was the nasal douche of Pinus with a washbottle, which the patient can do himself, bathing the whole of the pharynx.

DR. LAZARUS BARLOW, of the Westminster Hospital, who has been gravely ill in consequence of septic poisoning contracted while making a post-mortem examination, is reported to be slowly improving.

## The Operating Theatres.

### ROYAL FREE HOSPITAL.

REMOVAL OF ALL THE CONTENTS OF THE ORBIT FOR MALIGNANT GROWTH.—Mr. H. WORK DODD operated on a woman, *æt.* 38, who had been admitted for an ulcerating growth of the lids and orbit on the right side. The history of the case, Mr. Dodd said, was peculiar in that the patient said that eleven years ago she was troubled with a small pimple or nodular growth under the right upper eyelid, which growth was snipped off with scissors by a doctor. After a few months it presented itself again, and has since increased, sometimes slowly and sometimes quickly, to its present size, until four years ago it began to be really a visible trouble, about which period it commenced to ulcerate at the border of the lower lid. There had been no particular pain, with the exception of latterly some dull aching in the area. On admission the right eye was very nearly closed, the outer two-thirds of the eyelid were prominent and filled up in between them by exuberant granulations. There was distinctly to be felt a solid growth, filling at least the outer half of the orbital cavity and extending outwards under the skin beyond the outer edge of the orbit for about half an inch; the growth was apparently somewhat firmly adherent to the bone in this region, though at the outer part the skin moved freely over it. On separating the lids the eyeball was found to be displaced towards the nasal side of the orbit and to be buried in altered tissue. There was a fair amount of thin discharge; the vision in the eye was good, but the movements of the globe were limited, especially in the outward direction. There was an enlarged gland in front of the ear on the same side, which was hard and somewhat painful to the touch, the skin could be moved over it, and the gland itself was movable on its base, but not freely. The clinical appearance of the growth pointed towards a diagnosis of an epithelioma of a slow and quiet type though there existed a possibility of its being a rodent ulcer; there was no history of syphilis to lead to any suspicion of its arising from that source. To render the diagnosis more certain, some days before operation the patient had been put under an anæsthetic, and a small portion removed across the base and the edge of growth, so as to take ulcerated as well as non-ulcerated tissue for microscopical examination; the result of this had not been decidedly satisfactory, there being some doubt as to what the growth really was; it however was held to be of a malignant nature. Proceeding rather on the clinical aspects of the case than on the pathological, it was determined to remove the whole growth as far as possible, which would probably lead to the clearing out of the whole orbital contents. The patient having been placed under an anæsthetic, an incision was made starting just outside the punctum lachrymalis of the upper lid, carried upwards and outwards to just below the eyebrow, reaching the orbital edge at the junction of the middle and inner third, and then travelling along the orbital border a little below the eyebrow to about an inch and a-quarter outside the external canthus. The lower incision commenced in a similar place just external to the lower punctum, running down well on to the lower edge of the orbit and travelling outwards along its border in an

almost straight line to meet the extremity of the upper incision in such a way as to include the growth external to the orbit. The whole contents of the orbit were then loosened from the bone, starting from above and on the outer side, by means of the finger, the periosteum detacher, and the knife; finally, the optic nerve was divided as far back as possible with curved scissors and the mass removed *en bloc*, together with the portion of growth external to the orbit, and the upper and lower lids as circumscribed by the two incisions. The outer orbital border in the region of the growth was then attacked with the chisel and mallet; the superficial part of the bone round this locality being thoroughly chiselled away, after which the outer wall of the orbit was scraped with a spoon. The original incision was then continued backwards and outwards over the centre of the enlarged gland in front of the right ear in order to remove the gland and its immediately surrounding tissues; this was successfully accomplished. This last incision was closed by interrupted and continuous sutures. The two incisions encircling the orbit were brought together in front of that opening, after they had been loosened above and below, in order to cover the large and ugly cavity, a space being left about the size of a shilling a little to the inner side of the normal situation of the eye. The cavity of the orbit was stuffed with cyanide gauze, and suitable dressing applied externally. Mr. Work Dodd remarked on the absolute necessity of freely removing all tissues in the immediate vicinity of such a growth, and pointed out that even an eye which possessed good vision had to be sacrificed to attain that object, not to mention that the appearance of the patient had to be terribly altered for the worse. He remarked that it was quite possible that some facial paralysis might result from injury to the facial nerve, during the removal of the gland. He proposed, after a suitable interval, in addition to closing the opening as far as possible, which he had done, to put in skin grafts on to the granulating surfaces of the orbital cavity in order to change this surface into skin, so that the walls of the orbit would be lined with skin, thus doing away with all discharge, and at the same time protecting the cavity from external influences.

Three weeks after operation the patient was doing well, the wounds being perfectly healed; the cavity of the orbit had been most successfully grafted a week before by Dr. Cunning, Senior Resident Medical Officer, very nearly its whole surface being now covered with properly growing skin. There had been no indication whatever of facial paralysis.

#### Dublin Death-rate.

IN the Dublin Registration Area the deaths registered for the week ending Saturday, November 9th, 1901, represent an annual mortality of 23·8 in every 1,000 of the population. Within the city proper the death-rate ranged from 25·7 in the Clarence Street District to 30·3 in the South Earl Street District, and reached as high as 38·0 in the Lisburn Street District, figures which show how dependent the high death-rate of Dublin is on the tenement houses in which the city labourers are huddled.

#### Grants in Aid of Scientific Research.

WE are requested to call attention to the fact that the Odontological Society of Great Britain is prepared to receive applications for grants in aid of the furtherance of scientific research in connection with dentistry. For further particulars and forms of application apply to the Hon. Sec., Scientific Research Committee, Odontological Society, 20, Hanover Square, London, W.

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"SALUS POPULI SUPREMA LEX."

WEDNESDAY, NOVEMBER 20, 1901.

**"IDEALS IN MEDICAL EDUCATION."**

It is no secret that the changes made of late in the medical curriculum are viewed with scant favour. That some change was necessary scarcely required argument. The introduction of new subjects, the subdivision of others, and the bringing of a few more into greater prominence, without any being given up or their importance being diminished, could not go on for ever. As it was, the unfortunate student was overloaded to such an extent as to make anything like a satisfactory mastery of the subjects impossible. A fifth year was therefore added. That it has resulted in an improvement commensurate with the increased expense involved is very questionable. Unfortunately the change brought in its train in many places an increased number of examinations. The medical student's life is one continuous struggle with examinations. He has come almost of necessity to look upon each course solely as a preparation for an examination. He becomes an adept in discerning the points which are likely to have greatest examination value. The lecturer whose discourses are considered to most nearly suit the examination which is to follow is most carefully listened to; the professor whose lectures are calculated to enable the student to justly appreciate the great principles of the healing art, or to dip below the surface of the subject, rather than to help him to pass the examination, finds his discourses neglected. These teachers become, unwittingly, the greatest friends of the "coach." In an address on "Ideals in Medical Education," before the Melbourne Medical Students' Society (*Intercolonial Medical Journal of Australasia*), Dr. J. T. Wilson, Professor of Anatomy in the Sydney University, took an extremely broad view of the whole subject. Many of his remarks had reference to local difficulties, but he nevertheless points out in a masterly manner some of the defects of the systems which hold

generally in English-speaking countries. If we are not prepared to entirely abolish intermediate examinations he would favour "examinations only when the student is about to pass from one definite phase of study to another." The address well deserves the careful perusal of all who are interested in the subject of medical education at home and abroad. Dr. Wilson cautions teachers against taking too narrow a view of their duty, which is to train professional men rather than give a professional training. In his opinion it is possible to embody the whole ideal of an university in a medical school, yet he does not lose sight of the fact that Harvard Medical School, in the United States, has enacted that "it is their intention to require a preliminary college course in arts of four years' duration as a qualification for admission to the medical curriculum, also of four years." This is particularly significant in a country where the practical side of affairs is kept so well to the front. Johns Hopkins University has already this system in operation. Dr. Wilson believes that "the most serious charge brought against the curriculum with which" he is "most familiar is that the last two years of it are alone available for clinical work in hospital." His argument against this practically consists in asserting that since the student goes to hospital better prepared, he acquires a knowledge of clinical work more readily. "But," he says, "notwithstanding all this I am disposed to believe that we in Sydney have gone a little too far in the reduction of the period of clinical study to two years only." He would welcome the introduction of a "Lehrjahre" to the student course. This means adding a sixth year, except that the student would be able meanwhile to earn a small salary, or at any rate to live independently. The system of "elective studies" is discussed, and the prominence it has reached in that great land of inventions, the United States, is shown. It is stated that at Harvard, "in the Medical Faculty alone the staff consists of twenty-two professors and eight assistant professors, twenty-six instructors and demonstrators, forty-three assistant-instructors, and ten special clinical instructors independent of teachers in the preliminary scientific subjects, with an output of not more than about one hundred and thirty graduates per annum." One is tempted to ask, Do the teachers teach? The Professor of Anatomy of Yale University is quoted, "We already note," he says, "that the experience of the clinician can rarely do more than effect improvements in methods, while the new principles come from the laboratories." It might be added that only too often these new principles have had to be sent back to the laboratories for repairs after a very short time. It is curious to compare Dr. Wilson's complaint that clinical work once started fascinates the student into a neglect of the more scientific branches, with that of Graves in 1842, when he said "the chances are that the chief energies of his (the student's) mind will be mis-

spent with the fascinating experiments and doctrines of chemistry, electricity, magnetism, and the polarisation of light." Clinical work will ever remain the subject which will attract the large majority of medical students and win from them the greatest interest and industry, and it is well that it is so. One would justly tremble for the welfare of the public were it not that though the medical student is very heavily handicapped in his clinical work he is to-day as much attracted by the study of the problems which await solution in each patient he sees, as were the students of long ago.

#### THE TREATMENT OF PYLORIC CANCER.

FOR some years past surgeons in various parts of the world have exercised their ingenuity in devising measures having for object to obviate the distressing consequences of cancer affecting the neighbourhood of the pylorus. The symptoms associated with cancer in this situation are almost entirely due to the mechanical obstacle to the onward passage of the gastric contents created by the resulting stenosis. At first surgeons restricted their efforts to removing or circumventing the obstacle, either by manual dilatation, as suggested by Loreta, or by one or other method of gastro-enterostomy, thus short circuiting the upper part of the alimentary canal. The study of the post-mortem appearances subsequently emboldened surgeons to go a step further, and by removing the diseased portion of the stomach to attempt a radical cure. Although, so far, the results of this form of surgical intervention have not realised the, perhaps, too sanguine hopes of the operators, the measure of success has been sufficient to justify further observations. At present it is open to question whether the extra risks attending the major operation of pylorotomy, are compensated by greater comfort and prolongation of life as compared with the relief afforded by the comparatively mild operation of gastro-enterostomy. The relief to the urgent and distressing symptoms of pyloric stenosis afforded by the latter operation is immediate and pronounced, and the only drawback to its usefulness is the ephemeral duration of the improvement. In view of the extremely unfavourable condition of a large proportion of patients suffering from gastric dilatation following pyloric cancer it is urged by some eminent surgeons that gastro-enterostomy ought always to be performed in the first instance, advantage being taken of the subsequent improvement in general health to attempt the radical cure later on. Against this suggestion must be placed the fact that, as it is, these cases do not as a rule come under surgical treatment until the progress of the disease is such as to defy its entire eradication and any further avoidable delay is therefore to be strongly deprecated. This brings us to the question of diagnosis. Here, as in so many other departments of surgery, surgeons complain that they are not asked to operate until success is jeopardised or rendered impossible by the extension of the growth. Physicians defend themselves by

alleging the extreme difficulty of making an early and trustworthy diagnosis, and it cannot be denied that these cases do sometimes present well-nigh insuperable obstacles to a correct diagnosis. If we await incontrovertible evidence of the localisation of the disease in the region of the pylorus it will in the majority of instances be too late for effectual surgical intervention. It is open to question too whether further experience will enable us to surmount this difficulty which appears to be inherent to the anatomical circumstances. The only alternative is to cut the Gordian knot by having early recourse to an exploratory incision in all cases presenting the classic symptoms occurring in patients at what we may call the cancerous age. Special importance is attached, in the diagnosis of cancer, to the absence of hydrochloric acid in the gastric contents. In the discussion on a paper read at the last meeting of the Clinical Society of London by Dr. Moynihan, an abstract of which we published last week, it is pointed out that in 70 per cent. of the cases of gastric cancer the growth is so situated as to allow of its extirpation, and further, there is a curious absence of secondary growths in the liver. The present attitude of surgeons towards operations for cancer of the stomach, as was pointed out, is very much that which they took twenty years ago towards removal of the breast for cancer. Little by little the scope of the operation was enlarged so as to include the lymphatic area, with proportionally more favourable results. No doubt in the near future they will follow these lines in dealing with cancer of the stomach, removing lymphatics and other possible sources of recurrence, and thus advancing towards the object which they have in view—the radical cure.

#### THE METROPOLITAN ASYLUMS BOARD AND SMALL-POX.—I.

To say that the progress of preventive medicine must always be closely regulated by the thoroughness which attends its practical administration is simply to formulate a general law. In the United Kingdom there would be difficulty in citing examples of all degrees, both of excellence and of its reverse, in the matter of sanitary local self-government. Among a host of administrative bodies the Metropolitan Asylums Board stands out pre-eminently on account of its size, its importance, and of its completeness of organisation. The duties of the Board are multifarious. It deals with the infectious sick of the greatest city in the world, together with its insane population and the training and medical care of a great number of Poor-law and "remand" children. The centralisation of these branches of work has been necessitated by the vast and increasing size of the Metropolis, but the work of the Board conveys its lesson to every municipal and county sanitary authority throughout the Kingdom. The value of central control has been abundantly demonstrated by the measures taken to deal with the small-pox epidemic that has now obtained a

foothold in London. In the present day, with its increasing and rapid inter-communication between the "metropolis" and all parts of the Kingdom the maintenance of a first-rate line of defence against small-pox in London is a matter of importance to the safety of every town and hamlet, however remote, throughout the length and breadth of the British Islands, to say nothing of our colonies. Owing to the fluctuating nature of that malady, which we fain would liken to the flickerings of an expiring conflagration, it is exceedingly difficult to gauge the extent of standing hospital accommodation that should be maintained. To take a few illustrations: In the year 1885 there were treated in the Board's hospitals 6,146 cases of small-pox; in 1889 there were only 5; in 1893 the figures rose to 2,376; in 1898 they had again fallen to five; while in 1900 there were 66. Clearly the task of keeping up under these circumstances a means of defence in the shape of properly equipped isolation hospitals saddles the Board with a constant drain upon its resources. According to their own statement the cost to the metropolis, exclusive of ambulance charges, of this insurance against small-pox outbreaks is about £10,000 per annum. Considerable as this annual charge is compared with the number of patients treated, its value is tested by London's comparative freedom from small-pox, and when we look at the cost of past epidemics, both in lives and in money, and at the dislocation of trade thereby involved, it will not be deemed excessive by reasonable persons. In the present year, unfortunately, the resources of the Board are likely to be heavily taxed by the small-pox outbreak that is still steadily increasing in the Metropolis. When we consider the expenditure of energy and of money, both of which are poured out like water in the attempt to exterminate small-pox, and on the other hand the creation of an unprotected population that is bound to follow the retrograde policy inaugurated by Mr. Balfour's Vaccination Acts, we realise the inconsistency of the national attitude with regard to the whole question. The existence side by side of the Asylums Board small-pox organisation and of the "conscientious objector" is an anachronism, a ludicrous contradiction and a reproach. With regard to other infectious diseases, it is somewhat encouraging to note that the total admissions for scarlet fever, although they reached the high figure of 10,343, were 22 per cent. less than those of the preceding year. We are also glad to note that during 1900 no patient suffering from that disease was refused admission, a fact that recalls the inadequate provision that has provoked severe criticism for many years past. There has been an increase in enteric fever cases, chiefly owing to local outbreaks, some of which were of mysterious origin. Diphtheria is still on the increase, as the numbers of patients admitted to the Board's hospitals have increased steadily from 722 in 1889 to 7,873 in 1900. The total number of patients under treatment in the infectious hospitals for the year 1900 was 26,641,

with an average stay of 60.5 days. They were drawn from a district that covers an area of about 121 square miles, and comprises nearly 1,900 miles of streets and road, and nearly 600,000 inhabited houses, with an estimated population of at least four and a half millions. Taking the erratic behaviour of infectious diseases into consideration it becomes evident that it is an extremely difficult problem to determine the proper number of beds required for the accommodation of so vast a community. To that task the Metropolitan Asylums Board has come full of vigour and sound latterday sense and information. It has spared no expense in furnishing first-rate modern hospital housing and treatment to patients, while it has encouraged the study of the scientific aspects of infection. The Board has had an absolutely free hand in the expenditure of public money, and it has been our duty from time to time to criticise the action of the Board in various particulars. In our next issue we propose to comment upon several matters that in our opinion invite public consideration. On the whole, however, the work of the Board may be commended by reason of its earnest and thorough administration.

### Notes on Current Topics.

#### Marriages among the Deaf.

THE important bearing of marriages between persons one or both of whom are afflicted either in bodily or mental capacity is, perhaps, not sufficiently insisted upon. We pay far more attention to the breeding of our animals with a view to the improvement of a species than we do to our own. Even in the serious condition of mental deficiencies we do not stop to consider the possible effects upon future generations. Much has been written on the subject of heredity by able exponents, but the conclusions to which they arrive are seldom acted upon; perhaps if they were there would be less mental and bodily disease in the world, as well as less criminality. A not unimportant phase of the subject is the result of marriages among the deaf. Recently, Professor E. A. Fay has carefully examined the records of 4,500 such unions, and he has discovered that, while taking the marriages of deaf persons as a whole, nearly 9 per cent. of the offspring are deaf, as contrasted with less than one-tenth, or 1 per cent. of deaf children as a result of the marriages of normal persons. A very different and much more favourable result is found to obtain when the deaf persons have no trace of deafness in their families. Marriage of deaf persons without deaf relatives is no more likely to result in deaf children than any marriage in the community at large, while the marriage of healthy persons who, though not deficient themselves in hearing, have deaf relatives, is just as likely to result in deaf children as the marriage of the deaf. We do not think that Professor Fay has arrived at much that is new in his investigations, but the facts that he has deduced will bear frequent reiteration. There



is one point, however, to which we would wish to draw attention; it is by no means seldom the case that it is less the deafness that is transmitted than the causes which lead thereto. The chief causes of deafness arising from middle ear diseases are the occurrence of catarrhal conditions of the upper air passages, conditions which, perhaps, depend more upon adenoids than upon any other abnormality. The hereditary transmission of adenoids is by no means established with certainty, although there is strong presumptive evidence that they are so transmitted. Among children who are suffering with adenoids and their consequences there is often found in their parents a history of symptoms which points to their having similarly suffered in their earlier years. The comparatively recent discovery of adenoids precludes certain data upon the subject of their inheritance, but this is a deficiency which future generations will clear up.

#### Rate Supported Hospitals.

THE view that hospitals ought to be municipalised, that is to say, supported and governed by representatives of the ratepayers, has something to commend it, although we see no immediate prospect of any such transference of powers and responsibilities. Short of taking over the hospitals altogether, it might be left open to municipal authorities to subscribe to the maintenance of these and similar institutions. In the case of Devonport, power to do so was expressly embodied in a recent Act of Parliament, and an offer has accordingly been made to the governors of the Royal Albert Hospital of a yearly subsidy of £100, coupled, however, with the proviso that acceptance will carry with it the right to appoint three members on the Committee of Management. Under these circumstances the offer was declined with thanks, the governors feeling, no doubt, that the offer was but the thin end of the wedge which would gradually oust individual initiative from the control of the institution. It is a significant fact that the voting on the offer was equal, and the amendment declining it was only carried by regulating the voting power according to the amounts of subscriptions. The refusal is approved by some critics on the ground that other donors of £100 are not admitted to the Board, but this is hardly a fair comparison, seeing that the municipality occupies a fiduciary position in the disposal of funds, and is under a moral obligation to see that they are rightly applied.

#### Anglo-Saxon Energy and South African Refuge Camps.

THERE can be no doubt that the death-rate is disastrously high in the camps established by the military authorities in South Africa for the Boer refugees. From reports, the credibility of which must be accepted, the fact is established that the mortality reaches something like 264 per thousand per annum. To grasp the significance of that statement one has simply to remember that the average for the worst districts in London is nowadays about thirty, while in the central districts of India, when

in the throes of plague and famine, it falls short of seventy. The returns undoubtedly prove that the refuge camps must be unfitted for human residence by reason of bad sanitation, bad medical organisation, bad housing, bad feeding, or one and all of these or allied conditions of faulty environment. With the policy that made these camps necessary we have nothing to do. That matter is for the nation and the Government to settle. As medical journalists, however, we feel it incumbent to protest against the continuance of such a state of affairs, which can be due only to a defective health environment. In striking contrast to the apathy shown by the nation in the matter of this terrible refugee camp mortality may be taken the action of the Liverpool School of Tropical Medicine in attacking the mosquito pests of Sierra Leone. About £6,000 a year is being spent in that task, a sum that is subscribed freely by the British public. Surely, there would be no lack of response if those generous benefactors realised how Boer women and children are dying wholesale in British camps. The question of money, however, according to Mr. Brodrick, does not stand in the way of sweeping out these pestilential camps, compared with which the towns of Sierra Leone are mere health resorts.

#### "Medicinal" Vegetables.

IT is extraordinary what nonsense is presented to the public under the guise of medical information. No quackery is too blatant, no superstition too silly, no vulgar belief too extravagant, no fool's reasoning too fantastic to be dished up by the writer of medical paragraphs for the lay newspaper, who must have a poor opinion indeed of his fellow-countrymen if he is attempting to reach the level of his readers. A short while since a Sunday newspaper gravely published a mass of rubbish about the medicinal properties of various vegetables. Asparagus, it maintained, was of value to the lungs and kidneys. Carrots are "very good for the complexion," and celery is "useful for rheumatism and gout." Onions and apples are "soothing to the nerves," and horseradish is a good nervous tonic, while parsley purifies the blood and tomatoes are "excellent for the liver." Can it be that the physicians of Harley and Grosvenor Streets are all wrong? That, instead of prescribing hepatic stimulants, and this, that, and the other drug *secundum artem* of the therapeutic school in this year of grace 1901, they should deal with patients somewhat in this manner:—"My dear Sir,—After careful examination I find your liver is out of order, your nerves all to pieces, and your blood impure. Kindly eat asparagus at each meal, with an abundance of onions and apples, also tomatoes and parsley, and make horseradish sauce a standing dish. And then, that muddy complexion, we had almost overlooked that. Please add to diet eight ounces of boiled carrots daily." And yet the scientific authorities of *materia medica* were thought to have investigated the properties of our edible vegetables to the last letter.

### The Unqualified Assistant as a Court Asset.

THE practical value of a law is clearly the extent to which it is carried out. Acting upon that principle the medical profession will do well to see that the existing conditions as to the employment of unqualified assistants are properly enforced. The following case appears to fall within the rule of offences in that direction, as defined by the General Medical Council. At the Shoreditch County Court a medical man, Dr. Haddens, sued a tradesman for payment of three guineas for medical attendance. The defendant pleaded that his child had been attended, not by Dr. Haddens, but mainly by his unqualified assistant, whom he would not have allowed to attend had he been aware of the fact that he did not possess a medical qualification. There appears to have been no attempt on the part of the plaintiff to deny either that the assistant was unqualified, or that he attended the case. The judge ultimately allowed plaintiff one guinea to cover the cost of his own visits, while the obvious law was laid down that the fees of an unqualified assistant are not recoverable. The case points its own moral to medical practitioners, and should serve as a warning to the unpleasant complications that are likely to arise from the mistaken economy of engaging the services of unqualified assistants. In all likelihood the difficulties of the unfortunate plaintiff may not end in the local county court.

### The Contagiousness of Psoriasis.

PSORIASIS is one of the most common of skin diseases, but one the origin of which is still obscure. The question is frequently asked by patients "Is it catching?" and the invariable answer is "No." But are dermatologists justified in making such a dogmatic statement? In 1889 a French physician, Destot, scarified his arm and inoculated it with a psoriasis scab. In a few days an eruption appeared having all the characteristics of psoriasis, and this eruption recurred four times in two years. The diagnosis was probably correct, but, as in all similar cases, there is always the possibility of coincidence. A similar case has been recently reported in which a man is supposed to have acquired psoriasis through the operation of tattooing, he not having suffered from the disease previously. On the whole we cannot regard the evidence in favour of the contagiousness of psoriasis as conclusive. One of the chief arguments against this view being the fact that it is very common for one married person to have the disease for years without passing it on to the other.

### The Cause of Alopecia Areata.

THE aetiology of alopecia areata has for long been the subject of much controversy, some authorities maintaining that the disease is due to a parasite, others that it is of nervous origin. Till recently opinions were fairly evenly divided on the question, but lately Drs. Norman Walker and Marshall Rockwell have published the results of a careful investigation of sixty-three cases. In two cases pieces of

skin were excised, when organisms found in the follicles and cultivations were also obtained. In 70 per cent. of the cases seborrhœa was present. These observations, therefore, tend in favour of the parasitic theory of the origin of the disease. The question is, however, by no means settled, for the bacteriological examination of sections of skin from only two cases out of sixty-three can hardly be considered a sufficient proof.

### Women Residents in Hospitals.

WE were under the impression that the opposition to women doctors had to a great extent subsided, but an incident which has just come to pass at Macclesfield shows that the feeling is still rampant in medical circles. The fact that most incidents of the kind happen in the provinces is no doubt to be explained on the ground that in London, so far, no such appointments have been made in any of the large general hospitals. It seems that on the governors electing a qualified woman to succeed Miss Rose, who had held the post of senior resident, the honorary staff resigned in a body. It is quite possible that personal reasons may sometimes render it difficult to work on satisfactory lines with a female resident medical officer, and from this point of view every case must be judged on its merits. In the general proposition that women ought not to be allowed to occupy these posts we must admit we are quite unable to concur. Once women were admitted to qualify as medical practitioners it was too late to regard sex as a disqualification for any medical post. So long as women agree to work on professional lines, and so long as they do not subordinate the interests of the profession to their own, they have a right to fair treatment. It is only a question of time for qualified women to take their place in our ranks on terms of perfect equality. They are not likely to oust men from the higher posts for the simple reason that but few, if any, could adequately discharge the onerous duties which such posts entail, but that is not a reason for debarring them from obtaining the invaluable experience which the tenure of resident posts in hospitals offers.

### Herbalists and the Apothecaries Act.

IN an action brought against a Limehouse herbalist in the Bow County Court last week, at the instance of the Apothecaries Society, the defence was based on an Act the very existence of which appears to have been forgotten, viz., the Act 34 and 35 Henry VIII. This Act provides *inter alia* that "it shall be lawful to every person . . . having knowledge and experience of the nature of herbs, roots, and waters, or of the operation of the same by speculation or practice . . . to practise, use and minister in, and to, any outward sore, uncome wound, apostemations, outward swelling or disease any herb or herbs, ointments, bathe, poultice and emplaisters, according to their cunning experience and knowledge." Judge French held that this Act had not been repealed and gave judgment

in favour of the defendant, adding that "had there been any selling at high prices, any trading on the credulity of the public, he would have struck with a strong hand." It is true that this exemption only applies to the treatment of outward affections, but it is nevertheless a great blow to the already moderate efficacy of the Apothecaries' Act, and unless an attempt be made to maintain the powers and privileges conferred upon the Society by getting the judgment reversed on appeal, the field will be thrown open to unqualified practitioners of every kind, since they will only have to allege that they were treating some outward manifestation of disease to get "privilege of clergy," so to speak.

#### "The Times" and Quack Propaganda.

MEDICAL readers of *The Times* for some months past have been much exercised in their minds by the prominence which this eminently respectable journal has given to methods of medical treatment which, to put it mildly, do not repose on any sound scientific basis. To say nothing of the egregious pretensions of Mr. Alabone, who is pertinaciously referred to as "Dr." Alabone, a designation to which he was never entitled, a long telegram is devoted to the blatant utterances of one Dr. Gilman, of the Hahnemann Medical College, Chicago, who claims to have obtained uniform success in the treatment of cancer by "giving medicines which will supply the material for rebuilding the destroyed tissues," subjecting the patients at the same time to the influence of X-rays "for weeks or months as the case may be." Is it possible that a professor, even at a Hahnemann College, can be unaware of the well established physiological fact that destroyed tissues are never under any circumstances replaced? There is evidently someone on the staff of *The Times* who is imbued with distrust of what we may term the regular practice of medicine, and who cherishes a child-like credulity in respect of empirical claims, the more grotesque the better. It is obviously by an oversight that due publicity has not been given in that publication to the alleged curative action of an infusion of violets in cancer.

#### An Apology for Bacteria.

THE newly-elected President of the Dublin University Biological Association is to be congratulated on the happy form which his inaugural address assumed. It is by no means an easy matter to select a subject which will permit of being treated in a manner of interest to all the various elements which meet at such a meeting. The President's address must be sufficiently scientific to meet with the approval of the heads of the medical profession. It must be sufficiently free from ultra-scientific terms to permit it to be understood by the quasi-scientific layman. Dr. Travers Smith's address fulfilled these conditions admirably, and though perhaps there have been more scientific addresses delivered by previous presidents, there have been none which were of more general interest to their hearers. Dr. Smith's address was directed to dispelling

the popular belief that all bacteria and men are natural and deadly enemies. The popular fallacy of the supposition that mankind would be benefited by the suppression of all forms of bacteria was pointed out. The various functions which these much abused organisms play in natural economy is an important one. Not only do they remove dead animals, plants, and other waste materials but they aid in restoring the nitrogen to the soil which has been removed by plants, and so maintain the supply of fixed nitrates on which the continuance of the world so largely depends. Then many industries are largely worked on bacterial lines. In the making of the best butter, cultures of certain bacteria are used to flavour the cream prior to churning. In the manufacture of smoking tobacco, the crude leaves are subjected to various fermentative processes for which bacteria are responsible. In the preparing of flax for linen, bacteria again come to the aid of man. Consequently it is not too much to say with Dr. Smith—Prosperity awaits the country who scorns not to lavish time and money upon the cultivation, development, and utilisation of the lowliest of her subjects, the bacteria.

#### A Difference of Opinion.

A DISAGREEABLE incident occurred a day or two since at the Marylebone Police Court in connection with a charge brought against a casual pauper of refusing to perform his allotted task. The workhouse medical officer had certified him fit for duty, but as the magistrate thought he looked ill he obtained the opinion of the prison doctor. This official certified that the prisoner was suffering from ulcerated throat of some days' standing, whereupon the magistrate dismissed the case, stating that in future he should insist upon the attendance of the workhouse doctor in cases of this sort. After all it is only fair that the prisoner should have the advantage of substantiating his refusal to work, and the magistrate's decision may have for effect to make workhouse medical officers more careful in dealing with recalcitrant casuals, who are admittedly a very difficult class of persons to take seriously.

#### Criminal Experiments.

IF it be true, as reported, that a medical practitioner in New York has inoculated a nurse with bovine tuberculosis for the purpose of testing the truth, or otherwise, of Koch's recent statements, it is to be hoped that steps will be taken to punish what is unquestionably a criminal offence. The fact that the subject was a consenting party to the experiment would certainly not excuse, though it might attenuate, the gravity of the offence. *The Times* correspondent has probably grasped the situation when he describes the experiment as the deed of a "young gentleman known to be exceedingly prone to self-advertisement." Should anything untoward happen he may find to his cost that human life is too sacred a thing to be sacrificed in experiments conducted under conditions which must necessarily rob them of any scientific value.

### Poisonous Fly-Papers.

CONSIDERABLE interest attaches to a case heard recently at the Widnes Police Court, when a chemist named Bostock was summoned for selling arsenite of soda without observing the provisions of the Pharmacy Act of 1868. The county analysts reported that they had received a sample of fly-papers for analysis, and that it contained upwards of  $5\frac{1}{2}$  grains of arsenite of soda, whereby each fly-paper was made capable of killing two men. It appeared that a woman bought six papers from the defendant, and was not asked to sign any book, though under the Pharmacy Act the quantities and the purpose of the purchase should be entered in a book. The facts were admitted, but it was contended that entries were not necessary in the case of vermin killing poisons. Evidence was given for the defence to show that it was not the custom to enter fly-papers, and one witness admitted that he did not know that they were so strong. Finally the Bench dismissed the case on payment of £5 17s. 2d. costs, and declined to express an opinion. The case is an important one, for, if vermin killing articles, each of which contains enough poison to kill two men, can be bought by any person without let or hindrance there is every facility thus given to individuals of criminal intent, and the Act which is destined to prevent the too free sale of poisons becomes absolutely useless.

### Night Sweats in Phthisis.

ALL physicians know the difficulty of keeping the night sweat of phthisis in control. Almost every known remedy has been tried since the Greeks used agaricin down to the present. Graves and Stokes used Dover's powder, which in time gave place to mineral acids, zinc and belladonna, atropine, and a host of other specifics. To the long list Nolda adds tannoform, the external use of which he recommends. In seven out of eight cases in which he had the front and back of the thorax dusted with powdered tannoform it checked the sweating (*Berl. Klin. Woch.*). This method of treating the symptom has the advantage of not interfering with the digestive function, which is usually so imperfectly performed in such cases, neither does it in any way preclude the use of any of the other antisudorifics. The power of itself should prove an agreeable application to the skin and promote the comfort which is such an essential factor in producing sleep in such cases.

### Infection from Toys.

WE are all familiar with the pitfalls which are ever at our feet throughout our wanderings through life; we have heard of death in the pot, destruction in tinned meat, and disease in half a hundred other articles of domestic use. A very sensible letter in *The Times* now calls our attention to another possible source of infection, namely, in toys. The writer of this communication states that he recently had occasion to investigate the internal economy of one of those curious fluffy animals which children so delight in, and so often clasp in their arms when

they go to sleep. The creature, which came from one of the best toyshops in London, was stuffed with rags which could only be called filthy; there was among other things, a man's neck-tie, which was offensive, not only to sight, but to smell also, and which could only have come from the grimiest of wearers. One need scarcely speculate upon the possibilities of infection from such a toy as this. We feel sure that no parent who knew the history of the stuffing of rag-dolls bought in a toy shop would allow her offspring to run the risk of taking his favourite "Gollywog" or "Ludlow" to bed with him, or to cover it with affectionate childish kisses. Moreover, the remedy is obvious; cotton-wool is cheap and easily sterilised, and would make an admirable stuffing for such toys.

### Birmingham Consultative Institute.

WE thought that we had at last come to the end of the association which placed Dr. Irvine in so unpleasant a position, but a letter which appeared in a recent number of the *Birmingham Daily Argus* calls for comment in our columns. In this communication Mr. Arthur Chamberlain stigmatises the charge of advertising used against Dr. Irvine as "hypocritical and unfair," and makes a gratuitous and absurd attack upon Dr. Saundby. Mr. Chamberlain quotes the description given of Dr. Saundby in Kelly's Directory, and suggests that it is nothing more or less than a six-line advertisement. There could be no statement more absurd than this, for a physician of Dr. Saundby's standing needs no such advertisement. Mr. Arthur Chamberlain had done better by preserving a discreet silence after the failure of the Consultative Institute than by making an unwarranted attack upon a justly respected member of our profession. Luckily Dr. Saundby can afford to treat such attacks with the contempt they deserve.

### Physically and Mentally Defective Children.

THE London School Board has done good work lately in the education of mentally defective children. In the annual report on the schools for the special instruction of such unfortunates, presented to the Board by Mrs. Burgwin, it is stated that schools have now been opened in every division in London except the City, though it cannot yet be said that the accommodation in any division equals the demand. Between March, 1900, and March, 1901, 128 children were examined for admission to the special instruction schools and rejected, being imbecile. Few, if any, of these find admission into the Poor-law schools, and their only alternative is a home or asylum, accommodation in which is very limited. Added to these rejections comes a number of inmates of the schools who have been dismissed after a fair trial, as imbecile. Surely it would be a wiser economy to make provision for the permanent care of such cases as these? The work done in the schools has been exceptionally useful. Physically and mentally the teachers strive to make every child profit by

the instruction given, so that each child, according to his ability, may enter the ranks of the wage-earning community. Indeed, the work of these schools thoroughly confirms the truth of the sentence with which the report ends: "There is no more interesting phase of psychology than that of the development of a weak-minded or low grade child into an intelligent, self-guiding person, with due regard to the rights of others."

#### Plague at Odessa.

A SERIOUS report has reached London by telegram regarding an outbreak of plague in Odessa. Three cases of bubonic plague have occurred, so it is stated, in one of the city hospitals. In accordance with the official reticence that characterises Russian administration, it has been hitherto impossible to gain authentic information from the civic authorities. The importance of an outbreak of plague in a great grain centre like Odessa can hardly be over-estimated. From that port cargoes are distributed over the greater part of Europe, including the United Kingdom, to say nothing of African and Asiatic ports. One grave feature of the case is the enormous number of rats that live in the granaries and cannot fail, should the plague have secured a foothold in the town, sooner or later to carry the contagion to the cargo ships. Fortunately, the sanitation of Odessa is good, and the Governor has taken energetic steps to cope with the invasion. The report is likely to create no little stir in the United Kingdom, the interests of which are so closely involved in anything that affects the supply of grain from foreign countries.

#### Ptomaine Poisoning at the Leeds Infirmary.

AN inquest was recently held at Leeds to enquire into the death of a girl aged seven weeks, which was the second alleged to have occurred from ptomaine poisoning in the Leeds General Infirmary. The child was admitted on November 4th and died on the 6th. According to the evidence of Dr. Luckhoff, the deceased was suffering from inflammation of the eyes. Another child dying on the same day—the 6th—he was not satisfied as to the cause of death except by post-mortem examination. He made an autopsy, assisted by Dr. Telling, and they concluded that death resulted from ptomaine poisoning. The jury brought in a verdict in accordance with the medical evidence—that death was due to ptomaine poisoning, but that as to how the poisoning got into the system there was nothing to show.

#### The Advisory Board A.M.S.

THE composition of the Advisory Board which is to assist in shaping the destinies of the reformed Army Medical Service has now been made public, and, frankly, we think the list, so far as the civilian members are concerned, defies criticism. We can only hope that the terms and conditions of the appointment are such as to allow the Scottish and Irish nominees to accept the offer, in view of the extreme importance to their respective schools of

direct representation. It is worthy of note that the choice of the Government has fallen upon men all of whom have seen active service, and are, therefore, cognisant of the requirements of the State, on the one hand, and of the medical staff on the other.

#### The General Medical Council Election and "Service" Voters.

MEDICAL practitioners belonging to one or other of the Services, resident in the United Kingdom, who are desirous of voting for the election of direct representatives on the General Medical Council are invited to apply by post, enclosing their postal address, to the Registrar, and an announcement to this effect will be found in our advertisement columns. No time must be lost in complying with this injunction as the election is now near at hand, and it is to be hoped that these members of the profession will testify to their interest in its welfare by acquiring the power to vote.

#### Guy's Hospital.

AN appeal has been issued on behalf of Guy's Hospital for funds to enable the governors to complete structural amendments at a cost of £180,000, and to provide an additional income of £14,000 a year. There is no institution in the metropolis more deserving of support than Guy's, and it is to be hoped that in spite of the unfavourable circumstances of the moment this appeal will not be allowed to pass unheeded. We note that the medical and surgical staff of the hospital have contributed upwards of £2,000 towards the fund.

#### PERSONAL.

DR. MAURICE JOHN DOIDGE has been elected Mayor of Glastonbury.

MR. H. T. BUTLIN is to open a discussion at the Pathological Society on December 3rd on "Lymphadenoma in its Relation to Tuberculosis."

THE BISHOP OF LONDON unveiled a window in the chapel of the Cancer Hospital, Fulham, on Saturday last, in memory of the late Dr. William Marsden, who founded the charity in 1851.

DR. W. A. DINGLE, of Finsbury, has been presented with a silver fruit-basket and vases, in testimony of his good service to the inhabitants as honorary secretary of the Finsbury Square Committee.

DR. CHAMBERLAIN, of Pateley Bridge, Leeds, has sustained severe injuries as the result of being thrown from his horse. He was found lying unconscious in the road, but recent reports state that he is progressing favourably.

DR. GEORGE HENRY BROWNE, J.P., Medical Officer of Health to the Brynmawr Urban District, was thrown from his trap early last week and sustained a fracture of the skull which promptly proved fatal. His wife, who also sustained severe injuries, is in a critical state.

## THE ARMY MEDICAL SERVICE.

THE Secretary of State for War has selected the following as the Chairman, Vice-chairman, and members of the Advisory Board for the Supervision of Army Medical Services:—

Chairman.—The Director-General Army Medical Service, Surgeon-General William Taylor, C.B., A.M.S., M.D., C.M.

Vice-chairman.—The Deputy Director-General, Surgeon-General (temporary) Alfred Henry Keeagh, C.B., A.M.S., M.D.

Members—Officer E.A.M.C. (expert in sanitation): Major William Grant Macpherson, E.A.M.C., M.A., M.B., C.M., D.Ph. Cambridge. Officer E.A.M.C. (expert in tropical diseases): Lieut.-Colonel David Bruce, E.A.M.C., M.D., C.M.

Civilian Members.—Charles Bent Ball (Ireland), M.D., F.R.C.S.J., F.R.C.S. Eng.; Alfred Downing Fripp, C.B., C.V.O., F.R.C.S.; James Galloway (Scotland), M.A., M.D., F.R.C.S., F.R.C.P.; Edwin Cooper Perry, M.A., M.D., F.R.C.P.; Sir Frederick Treves, C.B., K.C.V.O., F.R.C.S.

## Scotland.

[FROM OUR OWN CORRESPONDENTS.]

## GENERAL MEDICAL COUNCIL ELECTION.

DR. NORMAN WALKER addressed a meeting in support of his candidature on the 12th inst. He said that he had no desire to attack the Council from any point of view. The Council was composed of Corporation representatives elected for safeguarding the legitimate interests of those bodies of Crown representatives to see that the interests of the general public were looked after, and of direct representatives who represented the views of the profession as a whole. The first duty of the Council was educational, and it was on the basis of medical education, in which every practitioner was vitally interested, that he claimed their support. The question of the position of primary scientific education had recently been brought up by the action of the College of Physicians, and, though he did not think that that body had gone about matters in the wisest possible way, he cordially agreed with the position they took up. It was not a mere matter of words whether they relegated chemistry, biology, and physics to a preliminary scientific course, and followed this by a four years' curriculum, or whether they included them in a five years' curriculum. By the former plan the student must pass the examination in these subjects before beginning his more professional course, and thus had four years clear for study. Space would thus be left for other important subjects, in particular for bacteriology, which should undoubtedly be introduced into the curriculum. The next duty of the Council was as regards examinations. The duty of the Council in this respect was to enforce a uniform standard, which they could easily do by extending the present system of visitation. It would also be advisable if at the present time a system of Imperial registration could be adopted, to replace the existing Colonial registers. As to removal of names from the Register that was a judicial matter, and each case was considered on its merits. He thought it a pity that there was only one penalty, but in his opinion the warnings issued by the Council were very efficacious, and, in addition, he believed that private warnings were given to individuals which never came under the notice of the general body of the profession. All these measures tended to the maintenance of discipline in the profession. As to the midwives question, that was a subject in which he had taken a deep interest for many years. He was entirely and absolutely opposed to the creation of an independent class of registered practitioners. His solution was that certain hospitals qualified to teach should be granted power to give certificates. This would do away with the system of private teaching and giving of diplomas, and the women, being properly trained, would have learned

when a case was one to which a doctor was required. It was obviously impossible to define a normal labour, and it was only by instructing midwives properly that this difficulty could be got over. As to the dispensing of drugs, there was no possible objection to the sale of medicine to patients, and the custom had the sanction of usage over great parts of England and Scotland. Even the sale of soap and tooth powder would not be interfered with by the Council; the only thing that body had set its face against was the sale of scheduled poisons by any unqualified person acting as an assistant. Personally, he entirely accepted the position of the Council. It had been said that there were three ways of dealing with any question: one might accept or reject it, or deal with it diplomatically. It seems to him that Dr. Robertson rejected the Council's decision, while Dr. Bruce dealt with it diplomatically. There was an attendance of about seventy at the meeting, which was presided over by Dr. Gibson. A number of questions were asked, from which it appeared that Dr. Walker preferred levelling the standard of present examinations to instituting a uniform State examination. A motion to support Dr. Walker's candidature was carried unanimously.

Dr. Chas. Robertson, of Glasgow, has issued an address to the practitioners of Scotland relative to his candidature. In it he claims for all medical practitioners the same rights as registered chemists—namely, that when an unqualified dispenser is convicted of selling a scheduled poison the master be not held liable. The constitution of the General Medical Council requires reform, and the direct representatives should be increased until they form a majority of the Council. Dentists ought also to have a representative. As regards the financial position of the Council, all bodies returning members ought to contribute to their expenses. The Council ought to seek Parliamentary powers to deal with counter prescribing, bone-setters, quacks, &c. It is, of course, no secret that Dr. Robertson's candidature stands or falls by his views on the question of the sale of poisons. Medical men in the West of Scotland maintain that they are liable to vexatious prosecutions for doing as their predecessors have done, and they feel aggrieved by the action of the Council in refusing to receive a deputation last summer, when the question was before the Council in its judicial capacity.

## PLAGUE IN GLASGOW.

No fresh developments are reported. The Town Council have decided that plague is forthwith to be included among the diseases scheduled under the Compulsory Notification Act, and that the regulation shall remain in force till December, 1902. The destruction of rats goes on merrily, and the Central Hotel is said to be almost free of them. They are a business people in the West: in addition to cleanliness and a moderate tariff, some hotels seek to attract visitors by claiming to be "rat proof."

## GENERAL COUNCIL OF GLASGOW UNIVERSITY.

At a recent meeting of this body, Dr. Munro Kerr moved that representations be made to the University authorities in favour of the provision of a midwifery school in addition to the present Maternity Hospital. Dr. Murdoch Cameron seconded the motion warmly, and said that he had already been promised £11,000 towards the equipment of such an institution. At the same meeting, reports of sub-committees dealing with medical education were presented, all of which strongly favoured the increase of practical instruction and a corresponding diminution of systematic lecturing.

## GLASGOW SOUTHERN MEDICAL SOCIETY.

This society opened the session with a meeting in the Ophthalmic Institution on Thursday evening last. Several patients were presented, and a collection of stereoscopic photographs portraying external diseases of the eye, and another collection of coloured pictures illustrating diseases of the fundus were exhibited. A special feature was the demonstration of the electrical equipment of the hospital. The Finsen lamp, a Tesla coil, and the X-ray apparatus were shown in operation. Thereafter Dr. Maitland Ramsay delivered a short lec-

ture on Hypopyon Ulcer, this also being illustrated by lantern slides and microscopic preparations. At the close of the proceedings Dr. J. Stewart, the president of the society, complimented the staff of the hospital on their admirable arrangements, and thanked Dr. Ramsay for providing the members of his society with an enjoyable and instructive evening.

## Correspondence.

[We do not hold ourselves responsible for the opinions of our correspondents.]

### UNTRUSTWORTHY SERUM.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Your editorial in this week's issue (November 13th) on the above subject refers to a report from St. Louis, U.S.A., of "an outbreak of tetanus in children following the injection of diphtheria antitoxin, resulting in eleven deaths." "This lamentable occurrence is on a par with that reported not long ago from Italy." I noticed also in THE MEDICAL PRESS AND CIRCULAR of October 30th that your Vienna correspondent mentions "three cases of tetanus resulting from the employment of the anti diphtheritic serum."

These occurrences remind me of an incident which happened in Germany about three years ago. At a meeting of scientists held in Dusseldorf, when the subject of diphtheria was under discussion, one of the members expressed a doubt with regard to the connection of the Löffler bacilli with diphtheria, for the Löffler bacilli were present in abundance in the mouths and throats in cases of slight gastric derangements and even in healthy persons, whilst they were absent in genuine cases of diphtheria. He had also the temerity to mention the clinical fact that the antitoxin inoculations give rise, in a number of cases, to heart and kidney diseases, and to general prostration from muscular paralysis. I am creditably informed that the gentleman narrowly escaped being lynched for his blasphemous thesis. To question the efficacy of a drug which had been acknowledged by the Faculty and printed in textbooks as a sovereign remedy!—that could not be tolerated.

Indeed, it would have been rather awkward, after cabling the good news to all parts of the world that "we have, at last, found an infallible remedy for the diphtheria scourge"; "antitoxin (as the name implies, antidote to the poison) acts like a charm"; "one inoculation causes the false membrane to shrivel up"; "diphtheria has lost its dread"—these and other pithy statements, with the authority of Professor X., who furnishes statistics confirmatory of the glad tidings; it would have looked foolish, after all the fuss, to turn round and say that it was all a mistake.

The muscular scientists have, by methods of their own, silenced contradiction; but, whilst we have been lulled into security and contemplate the existence of diphtheria with equanimity, having got an antidote to render it innocuous, there comes the distressing news from different parts of the world that the antidote is more disastrous than the disease.

I am, Sir, yours truly,  
M.D.  
Edinburgh, Nov. 16th, 1901.

### DEGREES FOR LONDON STUDENTS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The time is gradually approaching when definite steps will have to be taken to remedy the position of London students regarding the degree question.

The advantages of a medical degree in place of the old-fashioned licence to practice medicine are undoubted and are becoming more evident daily.

Universities are from time to time springing up in the provincial cities, and it is no longer considered necessary for the student of medicine to come to London to receive an adequate training or qualification in medicine, for the provincial Colleges now have teachers in their schools, and practical physicians and surgeons on the staffs of their hospitals, in every way equal to those in London.

Nor is this all. The provincial graduate in medicine, by merely passing a final examination over again, immediately after his degree final, can add the further qualifications of the London Colleges to his name. Not so the London diplomate, who, having once passed through his lengthy medical studies, in every way equal to and as arduous, but at a far greater pecuniary expenditure, as that of his more fortunate provincial brother, finds himself debarred from using the popular title of doctor, and is further cut off from obtaining that title by a lengthy residence at a provincial University, and has his examinations to re-pass from beginning to end.

London the greatest city in the world, and unable to offer an ordinary pass degree to her students! Smaller and less important cities enjoy this privilege, while more than one possesses two universities.

Surely, Sir, such a state of affairs is absurd. Can no one of influence be urged to move in support of a cause which everyone must own is a just and natural one? Are the Colleges too important a body to pay any attention to the wants and grievances of their diplomates?

Surely some combination of the London licensing bodies with the University could be brought about to grant a pass degree in medicine, while the University still continued to grant its present degree as an Honours one, and the Colleges their higher qualifications as heretofore.

Even a new University would not be out of place, with the Royal Colleges as its Medical Faculty; bearing in mind the significant fact, as pointed out by Mr. Collingwood in your last issue, that the population of London is equal to that of the whole of Scotland, which, however, possesses no less than four Universities.

If the right man would only choose to come forward in the right place, a difficulty could be overcome which would materially raise the status and position of the average London student so as to compare favourably with that of the student of the lesser provincial towns.

I am, Sir, yours truly,

R. LE GREY WORSLEY.

London.

### THE PROFESSION AND THE PUBLIC.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In my last letter with reference to the charge against the profession deliberately made and reiterated by Colonel Le Poer Trench, I observed that "if he stood alone or in a very small minority of the public capable of seriously holding and publicly asserting such a monstrous belief the fact would not be remarkable; but it certainly is a remarkable fact, and one well worthy full discussion that a large proportion of the public in every rank of life have equally little respect for the profession, have as little confidence in medical science, and are as ready to reject its authoritative opinion in favour of that of any pretender loud voiced and persistent enough in his claims to attention."

Two cases reported in the same number of your paper (November 6th) confirm my opinion. They are cases of a kind familiar to men in every department of the profession, although most often, perhaps, presenting themselves to the general practitioner. The average medical man, after spending from five to ten years over his compulsory education and in post-graduate work, after having made himself an accomplished professional man, more highly educated for his calling and more fully qualified for its exercise than the member of any other profession, finds himself in a position in which his professional standing is of the very smallest value to him—in a position in which it brings him no respect and gives him no advantage over the most vulgar and ignorant pretender. The base ingratitude of the average patient is exemplified in the case of Dr. Dowdall, whilst the estimation in which the profession is held in comparison with unqualified quacks is illustrated in the case of Dr. Wearing. In this latter case the parents of the child pay £2 to a herbalist and ten guineas to a bone-setter, who "reduced the dislocation" in a case of hip disease, and refuse to pay Dr. Wearing's bill, £2 12s., for his conscientious services, including an exact diagnosis of the wretched child's malady. Cases of a closely similar kind occur in the frequent experience

of practitioners in every rank of society, among simple and poor, educated and wealthy; among the classes figuring in the two cases I refer to, the families of a prison warder and a railway guard, and among people in the higher social grades like Colonel Le Poer Trench. If it is very bad for the profession, it is much worse for the public that such a state of things should continue, and it is surely worth inquiry, whether the cause is discoverable and if a remedy can be found.

The object of this letter is to start such a discussion. If the rank and file of the profession could be questioned I venture to affirm they would confess as a body that their lives have been mostly failures, and they would agree that for happiness as a medical man one needs to have the rare qualities which permit of continuous self-sacrifice in spite of almost complete disregard and lack of appreciation from those for whom it is made. To most men this is a demoralising if not a heart-breaking position. If one wants to estimate both the incredulity of the lower social classes with regard to real medical science and their amazing credulity towards gross and palpable pretence, one has only to look through the advertising columns of the popular newspapers, such as, in London, the *Weekly Times and Echo*, a paper, by the way, said to be the property of that distinguished philanthropist, Passmore Edwards. If one wants to recognise the injury inflicted upon the public health by the cynical quacks whose advertisements fill so large a space in the columns of that kind of paper one has only to attend for a time the out-patient department of a general hospital. It is hither that a great number of the victims of quacks gravitate after having been bled of their hard-earned savings, and having their diseases rendered chronic by maltreatment or hopeless by delay. If any proof were needed as to what may happen in this regard among the wealthier classes it might be found in Colonel Le Poer Trench's letters and in those of others of his social rank which during the still-continued discussion are appearing in *The Times*. These are "educated" people from whose education all scientific knowledge and all training of the intellect giving the power to recognise what is scientific reasoning and proof have been eliminated. It is this lack of scientific teaching and training among the whole people which is handicapping the British nation in every department of progress, and is in my judgment the cause of their deplorable attitude towards medical science and its professors. Not only are the people ignorant of science, but large numbers of the educated classes besides hate it and devote their lives largely to disseminating hatred of science and scientific methods by the most active and virulent propagandism.

I am, Sir, yours truly,

Nov. 6th, 1901.

UBIQU.

### THE "ELUSIVE SECRET" OF CANCER CAUSATION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It is amusing to read, in your issue of November 13th, Mr. Herbert Snow's description of the onset of cancer, as instanced in epithelioma (see p. 530): "A little crack casually occurs and refuses to heal. It is continually rubbed or chafed by some agency, which need not be specified. After a prolonged course of such treatment the ordinary phenomena of malignancy appear." On p. 510 of the same number Mr. Austin Meldon, ex-President of the Royal College of Surgeons, Ireland, says, more guardedly: "As yet we must look on the parasitic origin of cancer as more than probable. Beyond this we cannot go at present."

There is, however, in Dr. Creighton's article on "Vaccination" in the *Encyclopædia Britannica*, edit. ix., vol. xxiv., p. 25, the following:—"Cowpox 'undisturbed by the milker's hands' has no existence in the originating cow; it is the persistent irritation that makes it a pox"—a sentence which even surpasses the statement of Mr. Herbert Snow quoted above. We had better leave these two astute gentlemen to answer the question: Why does the one sore when irritated produce a pox and the other a cancer? But there is another question to be asked, namely, How came the editor of the *Encyclopædia* to insert Dr.

Creighton's article on vaccination, when he himself (then—that is, in 1888—a comparatively young man) says that "the views expressed in the present article diverge in many points from the opinions generally received among medical men," and, he might have added, from those set forth in the article on Jenner, to be found in an earlier volume (xiii.) of the same *Encyclopædia*.

I am, Sir, your truly,

D. BIDDLE.

Kingston-on-Thames, Nov. 14th, 1901.

P.S.—As Dr. Creighton admits cowpox to be an infective disease, and says "the milkers can usually point out some one cow in which the disease began," it is difficult to see why he should imagine it to arise differently in the "originating cow" than in those infected from that cow.—D. B.

### DEATHS UNDER CHLOROFORM.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It has been with far more than ordinary pleasure that I have read your remarks on the administration of chloroform in *THE MEDICAL PRESS AND CIRCULAR* of the 13th. They ought to be copied into every paper in the kingdom.

Some time ago I wrote to the same effect, urging that in all cases of deaths from chloroform the apparatus by which it was administered should be described, and the amount of chloroform used should be stated.

Why such a common sense requirement should be evaded I am at a loss to imagine, and in the public interest it ought to be demanded and insisted on.

I cannot conceive death occurring with the Krohne inhaler, when in the hands of any competent administrator, and I have again to-day taken chloroform in order to demonstrate to one or two medical friends its perfect action and freedom from, not only danger, but from any bad after effects, when properly administered.

I am, Sir, yours, &c.,

C. J. HARRIS, M.R.C.S., &c.

1, Kilburn Priory, N.W., November 15th, 1901.

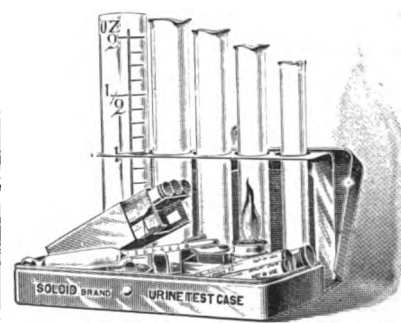
### Improved Medical Appliances.

#### THE "SOLOID" URINE TEST CASE.

THE improved "Soloid" Urine Test Case, manufactured by Messrs. Burroughs Wellcome and Co., which

we have been invited to inspect, is a marvel of compactness. The case, which measures 6 × 3 × 1½ ins. is in heavily nickelled metal. It contains a urinometer and an Esbach's tube (for the quantitative estimation of

albumen), also a spirit lamp and the various "Soloid" reagents for both the qualitative and the quantitative analysis of urine. Clear directions for use are given and all parts are replaceable. The case (for which there is supplied a doe-skin cover) can easily be carried in the pocket, and contains supplies of reagents sufficient for a large number of analyses. It is so much more convenient and businesslike to make analyses of urine at the bedside that this compact little case will doubtless be esteemed a boon by practitioners, especially by those whose practice extends over long distances. It is sold at £1 1s.

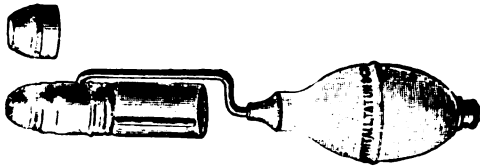


#### POCKET ATOMISER.

MESSRS. PARKE, DAVIS AND CO. have submitted to us an ingenious and very serviceable atomiser for the application of medicated fluids to the nasal mucous mem-



brane. It is very light and compact, and it delivers a fine spray. This apparatus is specially useful in administering sprays of cocaine, menthol, and adrenalin,



the last named agent, as is now well known, exerting a remarkable astringent and hæmæstatic action on mucous membranes. The price is 2s. 6d.

## Medical News.

### Medical Temperance Association.

A MEETING was held in the Library of the London Hospital on Friday last, Professor G. Sims Woodhead, President, in the chair, when about eighty students were present. Dr. J. J. Ridge introduced a discussion on the advantages of total abstinence. He advocated it on the ground that it was a more absolute and necessary safeguard from the evils of intemperance than vaccination against small-pox. He quoted Sir Andrew Clark, who had said, "It is when I think of all this (the effects of the abuse of alcohol) that I am disposed to give up my profession, to give up everything, and to go forth upon a holy crusade preaching to all men. Beware of this enemy of the race." He pointed out the physical advantages of total abstinence as regards athletics and examinations, and showed from the results of friendly societies and life offices that abstainers had on the average less disease and longer life. They were all total abstainers from something or other, such as opium. He considered there was greater reason to abstain from alcoholic drink as a beverage. The question of alcohol as a medicine was foreign to the subject. Some objected to take the pledge, but they did not require it as a condition of membership, although he supposed they were all looking forward to signing the Hippocratic pledge after passing the Conjoint Examination. Several students and others took part in a useful and animated discussion.

### Harveian Society of London.

THE annual dinner of the Harveian Society will take place at the Café Monico on Thursday, November 28th, at seven p.m. The President, Dr. D. B. Lees, will take the chair.

### Deaths under Anæsthetics.

A DEATH under an anæsthetic (it is not stated what anæsthetic) took place at the Queen's Hospital, at Birmingham, last week, the victim being a young man who was about to undergo an operation on his hand. Death supervened before the operation had even been commenced. A similar catastrophe is reported as having occurred at St. Thomas's Hospital, the victim on this occasion being a man, æt. 55, who succumbed during an operation for the removal of a cancerous growth. In this case the anæsthetic was gas and ether. This makes three deaths from ether in a fortnight, a most unusual series.

### Proceedings for Non-Notification.

MR. JOHN PADMAN, M.R.C.S., of Bloombury Square, W.C., was summoned last week to answer a charge of having failed to notify a case of small-pox. He was consulted by a man employed at a neighbouring hotel, who presented what Mr. Padman evidently regarded as suspicious symptoms, since he had the room inhabited by the patient stripped and disinfected, and vaccinated his fellow-employés. Nevertheless, he sent him home in a cab to Chelsea, where he was at once diagnosed to be suffering from small-pox. It was urged for the defence that this was the first case seen by Mr. Padman for many years, and he had failed to diagnose it in consequence, and the Bench dismissed the summons.

### Fatal Counter Irritation.

AN inquest was held last week on an infant at Heath, near Wakefield, who had died under peculiar circumstances. It appears that the infant was suffering from

bronchitis, for which the mother had applied a plaster composed of paraffin and linseed, the effect of which was to cause a huge blister, this, in the opinion of the medical attendant, having contributed to the fatal result.

### Ptomaine Poisoning or Diphtheria?

TWO children at Aston recently succumbed under circumstances which led the medical practitioner to diagnose ptomaine poisoning. As the evidence was not deemed satisfactory, the throats of the deceased children were submitted to bacteriological examination, which revealed in one the presence of the bacillus of diphtheria. Medical evidence was adduced to show that the symptoms of ptomaine poisoning presented great similarity to those of diphtheria, and a verdict of death from natural causes was returned, the foreman of the jury adding, however, that the jury were of opinion that the children were suffering from diphtheria.

### Another Anti-Vaccination Trick.

WHAT the local newspapers describe as an "amusing" vaccination case was heard the other day at Hounslow, where it was urged for the defence that no evidence was before the Court to prove that the child, the non-vaccination whereof was the subject of the proceedings, was really in existence. Ultimately the further hearing of the case was adjourned for the production of the certificate of birth. It is not easy to see what advantage can attend an objection which is merely vexatious in its character, and we are rather surprised that the Bench did not at once over-rule it.

### Ulster Medical Society.

THE first meeting of the session 1901-1902 was held in the Museum, Belfast, on November 7th, when the newly elected President, Professor W. Whittla, delivered an inaugural address on Some Worthies on the Membership Roll of 1886. He gave interesting biographical sketches of members of the Society who had died since that year. A vote of thanks, on the motion of Professor J. A. Lindsay, seconded by Dr. H. Whitaker, was accorded to the President for his address. The annual dinner is to be held to-morrow evening, November 21st.

### Memorial to Dr. Marsden.

ON Saturday last the Bishop of London unveiled a window in the chapel of the Cancer Hospital at Brompton, to the memory of Dr. William Marsden, its founder. The window has been erected through the generosity of the Worshipful Company of Cordwainers, of which Dr. Marsden was one time the Master.

### Zymotic Diseases in London.

THE number of patients under treatment in the hospitals of the Metropolitan Asylums Board suffering from small-pox continues to increase, the number on Monday being 353. There were 3,294 scarlet-fever patients, 1,266 with diphtheria, and 274 enteric cases, the last three showing a slight decrease on the return for the preceding fortnightly period.

### Damages for Arsenical Beef Poisoning.

AN action was tried at Manchester last week—the first of its kind—in which a consumer sued the publican for damages caused by the presence of arsenic in the beer, resulting in peripheral neuritis. The verdict was in favour of the plaintiff, for £50 and costs.

Conjoint Examinations in Ireland.—Royal College of Physicians and Royal College of Surgeons, Ireland.

CANDIDATES have passed the following examinations as undernoted:—

Final Professional Examination.—In all subjects: J. F. Fitzgerald. Completed examination: J. M. Barry, Miss M. E. Bridgford, C. W. Conry, A. D. C. Cummins, S. G. Gordon, W. R. Meredith, S. R. McCausland, F. G. Sharpe, R. C. Vernon, R. O. White, G. B. Wilkinson, F. W. Woods, Thos. Jos. Wright.

Diploma in Public Health.—Lieut.-Col. U. J. Bourke, R.A.M.C., M. J. B. Costello, M.B., &c., R.U.I., H. A. Dougan, M.B., D. P. French, M.B., E. Fox Symons, M.R.C.S., L.R.C.P., A. Moon, M.D., J. H. M'Anley, L.R.C.P.S.I., C. J. Powell, F.R.C.S.I., C. L. Sansom, F.R.C.S. Edin.

## Notices to Correspondents, Short Letters, &c.

**✉ CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

**GRADUATE.**—It would not be possible for the College to introduce a bye-law of the kind contemplated by our correspondent. No radical change could only be effected by means of a new charter.

**G. M. S. (Birmingham).**—A case is recorded of a man living with his leprous wife in Molaisi (the Leprosy settlement) for fifteen years, and having had by her fourteen children, and up to the present neither the man nor the children have developed leprosy.

### AN ADMISSION.

A MAN purchased some vermin-killer of a chemist, but not using it placed it in a cupboard where some time after it was taken in error by his mother-in-law, fortunately without fatal result. The man being asked some time after as to the character of the chemist said, "I can't say any good of him; he once deceived me over some vermin-powder."—*Chemist and Druggist.*

**M.R.C.S.**—Our correspondent is confusing the meetings of the "body corporate" at the Royal College of Surgeons (Eng.). The annual meeting, held in November, is inclusive of both Fellows and Members, at which an ample quorum is always obtainable, and no intention exists of abolishing it. The meetings of the "Fellows," however, independently, which were introduced a few years ago, are likely to cease to exist owing to the lack of interest shown in them. At the present moment "college politics" have passed beyond the pale of discussion.

**DR. LEWIS.**—The method of spinal anesthesia is still on its trial. So far it has found but little favour. Tropa cocaine is stated to have yielded the best results, being less toxic than the ordinary hydrochlorate of cocaine. But the procedure is one which a general practitioner would be wise not to undertake without expert assistance.

**DR. J. S. HORNER.**—Application should be made to the War Office.

**MEDICUS.**—The statement appears to us to be distinctly libellous.

**DR. ERNEST WILLIAMS.**—A trial might be made of Coley's Fluid.

**DR. S. B. O.**—Mr. Rudyard Kipling has, as far as we know, never studied medicine; he was a journalist before he became known as a writer of books.

## Meetings of the Societies.

### LONDON.

THURSDAY, NOV. 21ST.

**HARVEIAN SOCIETY OF LONDON** (Stafford Rooms, Titchborne Street, Edgware Road, W.).—8.30 p.m. Mr. Bucketon Browne: Twenty-five Years' Experience of Urinary Surgery in England (Third Harveian Lecture).

**CHILDHOOD SOCIETY** (Library of the Sanitary Institute, Margaret Street, W.).—8 p.m. Lecture.

**MEDICO PSYCHOLOGICAL ASSOCIATION OF GREAT BRITAIN AND IRELAND** (11, Chandos Street, Cavendish Square, W.).—12 noon. Educational Committee.—2 p.m. Council.—3 p.m. General Meeting under the presidency of Dr. O. Woods.

FRIDAY, NOV. 22ND.

**CLINICAL SOCIETY OF LONDON** (20, Hanover Square, W.).—8.30 p.m. Papers:—Mr. T. H. Morse: Case of Intracranial Section of the Second and Third Divisions of the Trigeminal Nerve for Severe Neuralgia.—Mr. W. Haward: A Case of Fragilitas Ossium.—Dr. S. H. Habershon: The Association of Movable Kidney on the Right Side with Symptoms of Hepatic Disturbance.

MONDAY, NOV. 25TH.

**ODONTOLOGICAL SOCIETY OF GREAT BRITAIN** (20, Hanover Square).—8 p.m. Annual Report. Communications by Mr. E. W. Roughton on "A Case of Alveolar Abscess, followed by Necrosis, Cellulitis and Fatal Hæmorrhage." Mr. Arthur S. Underwood on "Unexpected Outcome of a Regulation Case." Paper by Mr. W. Cass Grayson on "Science in Dentistry."

### DUBLIN.

WEDNESDAY, NOV. 20TH.

Dublin University Final Medical Examination. Sections A. and C.

THURSDAY, NOV. 21ST.

Council Meeting, Royal College of Surgeons.  
Dublin University Biological Association, Front Hall, Trinity College. 8.30 p.m.

FRIDAY, NOV. 22ND.

**Royal Academy of Medicine in Ireland.** Section of Obstetrics.—Specimens—The President: Two Specimens of Fibromyomata. Dr. Alfred Smith: Three Interesting Specimens of Fibromyomata. Dr. Jellitt: Uterus and Appendages removed for Chronic Salpingo-ophoritis. Papers—Dr. Jellitt: Notes on a case of Suppurating Ovarian Cyst and Intra-peritoneal Abscess, with specimen. Dr. E. H. Tweedy: Modern Technique of Vaginal Caesarean Section. Notes on a case of Caesarian Section.

Royal College of Physicians. 8.30 p.m.

MONDAY, NOV. 25TH.

Dublin University Final Medical Examination. Sections B. and D.

## Appointments.

**CLARK, PERCY J.**, L.S.A., M.R.C.S., Assistant Medical Officer to the London Dispensary, Spitafields.  
**CORBITT, J. A.**, M.B., B.S.E.U.I., Certifying Surgeon under the Factory Acts for the Bangor District of County Down.  
**DEMPSEY, PATRICK**, F.R.C.S.I., L.R.C.P.I., Surgeon for Diseases of the Throat and Nose to the Mater Misericordiarum Hospital, Dublin.  
**GLENNY, EDMUND**, L.R.C.P.I., L.R.C.S.I., Junior House Surgeon to Jervis Street Hospital, Dublin.  
**HARDWICK, ARTHUR**, M.D. Durh., L.S.A. Lond., D.P.H. Lond., Medical Officer of Health for Newquay, Cornwall.  
**IRVINE, H. B.**, L.R.C.P., L.R.C.S. Ed., L.F.P.S. Glasg., Dispensary Medical Officer for Belfast No. 13 and Castlereagh No. 1 Districts.  
**MCLORINAN, W.**, L.R.C.P.I., L.R.C.S.I., Dispensary Medical Officer of Cushendall and Waterfoot Dispensary, co. Antrim.  
**PADWICK, J. C.**, M.R.C.S., L.R.C.P. Lond., Certifying Surgeon under the Factory Acts for the Borough of Bridgnorth.  
**TARB, W.**, M.B. Edin., District Medical Officer, Yeovil Union.  
**TROMPSON, JAMES ARTHUR**, M.B., B.Ch., B.A.O.T.C.D., Senior House Surgeon to Jervis Street Hospital, Dublin.  
**TURNER, A. H.**, L.S.A., Medical Officer of Health for the Beaconsfield Urban District.  
**WALKER, EDYTHE M. S.**, M.B. Glasg., Assistant Medical Officer at the Warehouse Township of Toxteth Park, Liverpool.

## Vacancies.

**Bracebridge Asylum, near Lincoln.**—Junior Assistant Medical Officer. Salary £125 per annum, with apartments, board, attendance, &c. Applications to W. T. Page, junr., 5 and 6, Bank Street, Lincoln.

**Bradford Royal Infirmary.**—Dispensary Surgeon. Salary £100 per annum, with board and residence. Particulars of William Maw, Secretary.

**County Asylum, Mickleover, Derby.**—Senior Assistant Medical Officer. Salary commencing at £150, with furnished apartments, board, washing, and attendance. Also a Junior Assistant. Salary commencing at £120. Applications to the Medical Superintendent.

**County Asylum, Prestwich, Manchester.**—Junior Assistant Medical Officer. Salary commencing at £150, with board, furnished apartments, and washing. Applications to the Medical Superintendent.

**County of East Sussex.**—County Medical Officer of Health. Salary £200 per annum, with fees &c., for special visits. A list of the duties, &c., can be obtained of F. Merrifield, County Hall, Lewes.

**Glasgow University.**—Additional Examinerships in Medicine and Science, with special reference to Chemistry, Materia Medica, Zoology, Practice of Medicine and Surgery. Particulars as to dates emoluments, &c., on reference to our advertising columns.

**Leeds General Infirmary.**—Resident Surgical Officer. Salary £100 per annum, with board, residence, and washing. Applications to the Secretary.

**Middlesex Hospital.**—Medical Officer and Registrar to the Cancer Department. Salary £100 per annum, with board and residence in the College. Particulars of F. Clare Melhado, Secretary-Superintendent.

**Royal Sea Bathing Hospital, Margate.**—Resident Surgeon to act as Junior for six months, and then as Senior for the like period. The salary of the two offices is at the rate of £80 and £120 per annum respectively, with board and residence.

**Sheffield Royal Infirmary.**—Casualty Officer. Salary £100 per annum, with board, lodging, and washing. For duties of post apply to the Secretary.

## Births.

**ATKINSON.**—On Nov. 14th, at Elmhurst, Hampton Hill, N.W., the wife of G. L. Atkinson, M.R.C.S., L.R.C.P., of a daughter.

**OSBORN.**—On Nov. 11th, at Ennismore House, Dover, the wife of Francis Arthur Osborn, L.R.C.P. Lond., M.B.C.S. Eng., of a daughter.

**PAUL.**—On Nov. 11th, at 26, Queensborough Terrace, W., the wife of J. E. Paul, M.D., of a son.

**RENDALL.**—On Nov. 17th, at Ewell, Surrey, the wife of Percy Rendall, M.D., of a son.

## Marriages.

**HARRIS-BEDELL.**—On Nov. 9th, at Stowmarket, Robert James Harris, M.R.C.S. Eng., L.R.C.P. Lond., of Rochdale, second son of the late Henry Harris, M.R.C.S. E., of Dermarkt Hill, London, to Ethel Marie, eldest daughter of the Rev. Alfred Bedell, of Stowmarket.

**HYDE-BOLLESTON.**—On Nov. 12th, at St. Mary-le-Strand, London, Patrick G. Hyde, M.B., B.A.M.C., elder son of the late Col. Robt. Hyde, R.A.M.C. to Minnie, only daughter of the late Archibald Bolleston, of Drogheda.

**NEWBOLD-BARROW.**—On Nov. 13th, at St. Cuthbert's Church, Darlington, Addison John Newbold, Takuna, New Zealand, to Fanny, widow of Charles A. G. Barrow, M.B.C.S., L.R.C.P., Sutton, Surrey, and younger daughter of the late S. E. Piper, F.R.C.S., Darlington.

## Deaths.

**FARE.**—On Nov. 10th, at Hampstead, Arthur H. E. Fare, only son of John W. Fare, M.D., L.D.S., of 64, Brook Street, Grosvenor Square, W.

**SMEE.**—On Nov. 11th at his house, The Grange, Carshalton, Alfred Hutchison Smee, M.R.C.S., J.P. for Surrey.

**TAYLOR.**—On Nov. 11th, at his residence, 8, Grove Park, Liverpool, in his 80th year John Stopford Taylor, M.D.

# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

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## The Harveian Lectures, 1901.

TWENTY-FIVE YEARS' EXPERIENCE  
OF  
URINARY SURGERY IN ENGLAND.  
DELIVERED BEFORE THE HARVEIAN SOCIETY OF  
LONDON, NOVEMBER 14TH, 1901.

By G. BUCKSTON BROWNE, M.R.C.S.Eng.

### ABSTRACT OF LECTURE II.

GREAT improvement has taken place in the treatment of enlargement of the prostate gland during the last quarter of a century, and the great success of modern treatment is undoubtedly based upon attention to antiseptic detail, better surgical instruments, and greater skill and knowledge in their employment. The prospects of the prostatic patient have of late been painted in the blackest possible colours, but if the patient be not careless, and if he be judiciously treated, I would say that he was more likely than not to live to a considerable age. The prostate is a sexual organ; it appears to exercise no urinary function whatever, although why the organ undergoes enlargement is not very clear. I think the affection is more common among the sedentary and well-to-do, but it is found among men who are the very reverse of this. It certainly is often seen after a second marriage, or after a marriage late in life, but on the other hand, I have met with great enlargement in men remarkable for their lifelong asceticism, celibacy, and piety, so that with regard to the ætiology of prostatic enlargement one is still at sea. If pressed, however, to advise how best this malady is to be avoided I should advise plain living, exercise on foot, and very moderate worship at the shrine of Venus after fifty years of age. It has often been remarked in writings on the enlarged prostate that if a prostatic patient who fails to empty his bladder be left alone a time comes when cystitis occurs, and the urine becomes cloudy and offensive. This is not so in the vast majority of cases unless instruments have been used, and almost always is due to some imperfection in the antisepticism employed. We will therefore begin by a consideration of the practicable antiseptics of catheterism.

For many years I have provided the patient requiring the use of the gum elastic or rubber catheter, with the following outfit:—A tube of antiseptic pellets, one of which dissolved in a pint of boiled water, yields 1 in 1,000 of perchloride of mercury. A pint bottle. A glass tube 13 inches long, 1½ inches in diameter, and fitted with a cork and stand. A box divided into seven compartments, each compartment holding a catheter, and labelled after the days of the week, made of cheap material so as to be

burned when soiled, and easily replaced, or of tin, and therefore easily purified by boiling. A pot of plain white vaseline, or with the addition of 5 per cent. of oil of eucalyptus. In his bedroom the patient is directed to keep a vessel with a lid, filled with water which has been boiled, and a supply of clean, small, soft, rough towels, so distinctive that they are not likely to be used for ordinary purposes. The patient dissolves a pellet in the pint bottle filled with boiled water, and from this pint he fills his upright glass tube. We will suppose that his catheters are handed to him in a pure state. He uses a catheter at bedtime, withdraws it, wipes it, and then washes it in soap and water, and places it in the upright tube for the night. The catheter being upright in the tube, the inside is thoroughly exposed to the antiseptic solution, and there is no need to have interiors of catheters smooth and polished, as has been proposed, which adds to their expense. If the catheter has been put into the tube at bedtime it can be taken out the next morning, rinsed in water which has been boiled, dried, and put away in its compartment in the seven-compartmented box, until its day for use comes round again. If a catheter is required four or five times in the twenty-four hours it can, after each using, be washed and put back into the tube during the day of usage, although one finds in practice that simple washing during the day is sufficient if the catheter have its antiseptic bath at night. Men engaged during the day away from home, and travellers, carry two or three or more clean catheters in little metal boxes (which can be boiled) in their pockets, transferring the catheters when used to another pocket, and waiting until evening and their bedroom is reached, before washing them all and placing them in the antiseptic solution. One tubeful of perchloride solution will purify five or six well-washed catheters. Gum elastic catheters by good makers will bear twelve hours' immersion in 1 in 1,000 of perchloride of mercury well, and carefully used in this way will last for years. Vulcanised indiarubber catheters may, if desired, be left in this antiseptic bath altogether, without sustaining any injury. The receptacle for the lubricant employed should be small, so that the latter is frequently renewed, and the former should be frequently cleaned. The glans penis must be kept clean with soap and water, and the hands well washed. If these simple directions be carried out the urine will keep sweet and clear, and cystitis will never be set up. All metal instruments, such as silver catheters and vesical and urethral sounds, should be boiled, and no prostatic patient should be touched by any instrument which the surgeon is not perfectly satisfied with, and would not use, if necessary, upon his own person. For, if one impure contact be made, the patient may never be the same again, and it may be the starting point of almost endless trouble.

At one time I thought that the bladder never became infected unless impure instruments had been used, but I have had occasion to change this view, having found bacterial urine in the male bladder, virgin to all instruments, but this is very exceptional, and we must insist upon practicable antisepticism in urinary surgery.

When an elderly man requires the use of a catheter, it may be that he simply fails to empty the bladder by his natural efforts to the extent of a few ounces, or that he has an acute attack of retention of urine, or that he has for a long time failed to empty the bladder, that organ having become distended and containing habitually a large quantity of urine, the urine passed naturally being simply overflow. But whatever the precise reason for the catheterism, the patient may be said to be standing on the brink of a precipice, and the surgeon who comes forward to lead him to firmer and safer ground must act from the very first with caution, otherwise it is possible that both surgeon and patient may fall into the abyss, the patient losing his life, and the surgeon his reputation. In other words, the absolutely necessary catheterism may result in illness leading to the death of the patient, and to the destruction of the surgeon's reputation as a healer of men. Here, just as in the surgery of stone, we are face to face with urinary fever, and we must act from the very outset so as to avoid it if possible. Instrumentation must be gentle and skilful, and the patient be kept warm and quiet, for exposure to cold, and shaking of the body, as in travelling, both tend to still further embarrass the renal action if it has already been disturbed by catheterism. Therefore it is always well to attend the patient in his own warm room, and elderly feeble men should be kept for a few days altogether in bed. If a patient has sought advice in time, and has been properly attended to, he will probably never have complete acute prostatic retention of urine, and certainly will never come to the chronic state of retention of urine where the bladder is full and the urine dribbles away. If a patient come to acute retention of urine, he certainly has to be introduced to the catheter, under the most unfavourable circumstances, and with very little ceremony. The bladder must be relieved as speedily as possible, for the longer the retention the less likely is the bladder to regain its contractile power. It is in these cases that so often great difficulty is experienced in passing a catheter, and catheterism proving unsuccessful the patient is subjected to some formidable operation. We often read in the medical press statements of which the two following are fair examples. A surgeon writes of his patient, *æt.* 81, suffering from retention, "The prostate as felt per rectum was enormously enlarged, and no catheter could be passed, the growth blocking the urethra completely."

Another surgeon writes of his case: "After this it was impossible for two days to introduce a catheter." In both these cases the patients were promptly castrated. Now in such cases as these there is no doubt as to the existence of a urethra from meatus to bladder; I take it that there was no urethral stricture, and I do not admit that there is such a thing as prostatic stricture, therefore the only reasons why a catheter did not pass along the urethra and into the bladder was that the canal was tortuous, that is to say, irregularly bent and winding; and it is obvious that, given faith, determination and skill, which in this connection is only another term for experience, it must really have been possible to pass catheters into these bladders. I wish, indeed, to take this opportunity of asserting most emphatically that there are no cases of prostatic disease where it is impossible to pass a catheter into the bladder. When once a catheter is passed, the patient is on the high road to recovery, and he is spared the risks of severe

surgical procedures when, owing to his state of health and his age, he is particularly ill-fitted to be the central figure in an operation scene, at a time when "the keepers of the house shall tremble, and the strong men shall bow themselves, and the grinders cease because they are few, and those that look out of the windows be darkened." If a catheter will not pass readily in a case of prostatic retention, it will be because the curve forwards of the vesical end of the urethra is too acute for the instrument to follow it, or because the point of the catheter has caught in one or other of the two prostatic sinuses on either side of the *caput gallinaginis*. These sinuses form most perfectly contrived pockets or traps, which receive the point of the instrument, and effectually bar its onward progress into the bladder. When, therefore, the introduction of the catheter is arrested in these cases the point impinges upon the posterior wall of the urethra, or is caught in one of the pockets situated in that wall. It follows that for successful introduction the point of the catheter must hug the anterior wall of the urethra, and so the whole art of catheterising the prostatic urethra with soft instruments consists in making their points avoid the posterior wall. In successful prostatic catheterism one of two things always occurs—either the catheter takes the form of the urethra or the urethra that of the catheter. In the first case, when the catheter conforms to the urethra, the instrument must necessarily be a soft one, and when a soft one is employed it is undoubtedly better for the patient. The india-rubber catheter is the safest of all, and will often pass when all others have failed. Indeed, Mr. Jonathan Hutchinson (the introducer of the rubber catheter) considers that there are no cases where it will fail, and in his skilful hands it has been a great success. It will be well always to begin with these catheters. But in my experience, especially if other instruments have been previously unsuccessfully attempted, this catheter may not always pass, and it will then be well to try the *coudee* catheter, keeping the beak well upwards all the way in. Next in point of usefulness comes the *bicoudee* catheter, which is a very efficacious instrument, especially when the difficulty arises from the prostatic sinuses. The olivary catheter, and the English gum catheter are rarely of use in cases of real difficulty. The value of the rubber and of the *coudee* catheter may in certain cases be much enhanced by the use of a metal stylet. Metal stylets are of three kinds: iron, lead and silver. The iron stylet gives form and strength to the main body of the catheter, while the end of the catheter may be left free to follow the curve of the urethra. The leaden wire gives substance and backbone to the catheter without rigidity, and I know no more invaluable instrument in cases of great difficulty than a rubber catheter fitted with a leaden stylet, stopping short of say three inches from the eye of the catheter. The silver stylet occupies a position between the other two; it is very yielding and at the same time full of spring, and if well curved will often carry a soft catheter safely through a greatly deformed prostatic urethra, when the curve forwards close to the bladder is very acute. If no soft catheter, either with or without a stylet, can be passed, then we must make the urethra conform to the catheter, in other words we must use a silver instrument. The very worst cases can always be relieved by a silver instrument if the patient be anaesthetised, and if the surgeon guide the point of the instrument with his left forefinger in the rectum. I have found a large silver catheter, No. 14, with a short curve and fitted with a gum stylet very useful. It is too large and blunt to catch in the prostate sinuses, and the short curve comes readily forward

on depressing the shaft of the instrument. The gum stilet is useful in preventing plugging of the catheter from blood clot. After the bladder has been emptied, a soft catheter can always be passed in, if moulded on an iron stilet to the exact shape of the successful instrument.

But perhaps the most grave and anxious cases are those where the retention has been allowed to become chronic. No surgeon should consent to treat such cases as out-patients. In such cases catheterism must be commenced with care, and with every antiseptic detail, and the bladder should only be very gradually emptied. I generally practice catheterism every six hours, and if about seventeen ounces be drawn off each time it will be seen that, supposing the original contents of the bladder to be forty ounces, it will take four or five days before any one catheterism empties the bladder. If any pain be experienced towards the end of catheterism, the catheter should at once be withdrawn. If these largely distended bladders are suddenly emptied there is almost sure, within a few hours, to be some hæmorrhage from the vesical veins, which have been too suddenly relieved from a condition of chronic and severe pressure, the kidneys suffer severely from the shock, urinary fever follows, and the patient almost invariably dies; while if these bladders are only slowly emptied there may not be a rise of temperature, and, if one may so express one's self, not even a pus or blood corpuscle may be seen throughout the treatment. All depends upon close and constant surgical attention, and perfect submission on the part of the patient. If a prostatic patient be properly introduced to the catheter, and if necessary continues to use it with care and cleanliness, his prospects of life are good. There are, however, exceptional cases, where there are unusual difficulties and sometimes complications, and where simple catheterism will not alone suffice or is impossible. These are the cases which have been unfortunate in their introduction to the catheter, where cystitis and possibly intense irritation have been set up—cases where catheterism is very difficult, and where auto-catheterism is well-nigh impossible, owing to blindness, shaking palsy, crippled hands, and even the loss of a hand. These latter difficulties are, of course, got over by securing, whenever possible, the services of a good attendant. Then there are the cases where the prostate is very much enlarged, and often enlarged into the bladder, the prostate projection acting like a foreign body, and causing great irritation, and cases where, hidden away but none the less irritating and torturing, there is a stone in the bladder, not to be detected by the ordinary method of search by a sound introduced through the urethra. A prostatic case where the calls to empty the bladder are constant, and where perhaps catheterism is difficult and painful, and the relief obtained by catheterism evanescent, and where no vesical calculus can be found by the ordinary method of examination should in the first place always be thoroughly made a patient. He should be kept at rest in a warm room. His catheter should be introduced rather too often than too seldom, by a skilled attendant. The bladder should be washed out by mild solutions of nitrate of silver, boro-glycerine, or glycerine and borax. Antiseptics should be administered by mouth, such as boracic acid or urotropine, and the bowels should be kept gently active. If the case is one of simple inflammation the improvement which may take place is often astounding, and the improvement can often be rendered permanent by the patient learning exactly how to take care of himself. But if improvement does not take place, a careful examination should be made under an anæsthetic, a calculus may in this way often be

detected, while the extent of the prostatic growth may be defined by the finger in the rectum, and the sound in the bladder. During such an examination, it will be well also to use an evacuating tube, and a lithobriety aspirator should be employed, in order to wash out any irritating phosphatic concretion which may have eluded detection by the sound. If a stone be found it can be crushed and removed, unless for any special reasons it is thought best to perform lithotomy. But supposing lithotomy was not performed, and that in spite of all done so far the patient's difficulties continue, it becomes a question what the next step should be. Many would, under such circumstances, recommend vasectomy, and others, bolder still, would advise the removal of the testes. Now nothing that I have ever met with has recommended these operations to me. I have never performed either of them, for I have seen so many patients after these operations, not one whit the better for them, but in many ways the worse, that I have put them aside as even worse than useless. I believe that castration does no real good in genuine cases of prostatic enlargement, and I know that it is fraught with great dangers. Many patients become insane, many become decrepit, and many sink altogether under the operation. The same remarks apply to vasectomy, and as for single vasectomy it certainly appears to me that such an operation ought never to be performed.

I am satisfied that there is only one thing to do for a prostatic patient, whose sufferings cannot be cured or mitigated by the treatment already discussed, and that is to open the bladder supra-pubically, in order to explore digitally for stone, or tumour, and at any rate to obtain drainage and rest for that organ. No attempt should be made by the perineum, but the bladder should be opened above the pubes, where, however large the prostate may be, the finger can reach every nook and corner of the bladder and deal with whatever may be found. I would in passing, point out the importance of opening the bladder in such cases upon the point of a staff. When the prostate is large, that organ often comes up well above the pubes, and unless a staff is employed it is possible to incise the prostate and not the distended bladder, and thus cause serious embarrassment and trouble. It is quite curious how often a bad prostatic case will prove to be really a case of calculus, often hidden away in one of the many pouches to which such cases are subject. When once the finger is in the bladder, these stones, with care, are easily found, and generally easily turned out, and the case from being one of anxiety, uncertainty and disappointment, becomes a brilliant success. If a stone be found and the intra-vesical prostate is not very large, the prostate had better be left alone, but if there be much intra-vesical growth it will become a question for the judgment of the surgeon whether or not it should be attacked and removed. If no stone has been found, and there is considerable intra-vesical growth, I think it will be good policy to attack the growth by the performance of the modern operation of prostatectomy. Prostatic hypertrophy may be either (1) extra-vesical, (2) intra-vesical, or (3) both extra- and intra-vesical. It is the intra-vesical growth which chiefly causes difficulty in micturition, and, in my opinion, it is the growth which can be removed with reasonable safety. The vesical urethral orifice should be left with nothing surrounding it, but level and continuous with the floor of the bladder. Quite lately, although prostatectomy has been a recognised operation for twelve years, there has been much discussion about the "Total Extirpation of the Prostate by Enucleation," and it has been heralded as a new and most promising epoch in operative surgery. But surely such phraseology is misleading, and no anatomist

would use such terms. The prostate can no more be extirpated without the use of the knife than can a piece of intestine; it is absolutely one with the urethra and bladder. The phrase total extirpation of the prostate has been used in error, and by surgeons who have been fortunate in having only met with the simpler or adenomatous form of prostate hypertrophy, where large masses are easily shelled out.

Then again, in connection with prostatectomy, it has been denied that when the bladder has long been dependent upon the catheter, say for twelve months, it can regain its natural expulsive power when the prostatic obstruction has been removed. I have proved that the bladder can act naturally and completely, and for many years too, after the removal of prostatic obstruction (Medical Society of London, March 6th, 1893). I would, therefore, strongly recommend all prostatic patients and their advisers to be content with the catheter life as long as it is tolerable, and in the vast majority of cases with reasonable care it will remain tolerable into extreme old age, until the end comes probably through other channels. I believe, as Mr. Jonathan Hutchinson once said to me, "good surgery may often be combined with bad practice." The work of the world is not always done by those who are completely well. It is not wise for the elderly to run grave risks only on the chance of obtaining complete comfort. There is much truth in what Thomas Hardy says of one of his most fascinating heroines, "in considering what she was not, he overlooked what she was, and forgot that the defective can be more than the entire."

## THE X-RAYS AS A MEANS FOR THE EARLY DIAGNOSIS OF TUBERCULOSIS. (a)

By DR. ESPINA Y CAPO,

Of the Royal Medical Academy of Madrid, Professor of Tuberculosis in the Provincial Hospital of Madrid, Inspector of Public Health, &c.

My work comprises three parts: first, radioscopy; secondly, radiography; and thirdly, the technique of both in relation to tuberculosis. In the first part I shall speak of radioscopy in cases of sound and tuberculous lungs; in the second of the use of radiography in the different stages of the disease, whilst in the technical section I shall refer to the best method of obtaining the most satisfactory results in both.

*Radioscopy.*—Radioscopy as a means of diagnosis in tuberculosis, since its appearance in the clinical field, has been one of the means in which the greatest hopes have been placed, so much so that since the fourth congress on tuberculosis held in Paris, it has been considered to be the equal in importance both of percussion, superficial and profound, and of auscultation.

Partisan as I am of the parasitic doctrine, I will not treat of the radiographic diagnosis of obvious pulmonary tuberculosis, because the analysis of sputum, and the presence in it of the bacillus of Koch, affirm so positively the existence of tuberculosis, that no physician can cavil with this method. Radioscopy, in the case of open tuberculosis, serves only as a means of settling the topography of the lesions, and although this is very important, it does not deserve to fix our attention, because we prefer to employ our time studying the true use of the X-rays in the diagnosis of pulmonary tuberculosis in its first period full of doubts, and in which thera-

peutical intervention, being more rapid and convenient, is also more efficient.

There is another question of transcendent importance, in which the X-rays have assisted our investigation with such clearness, that this peculiar aspect of the question justifies our fixing it in our attention. I refer to glandular tuberculosis, the commencement, in many cases, of pulmonary tuberculosis, and in all the inseparable companion of the disease.

Radioscopy constitutes a powerful means of studying the dynamic forces. It is not possible to see by radiography all the functions and all the movements that characterise each function. For this reason the normal physiology of, for example, a joint during the different phenomena which constitute movement and action, can alone be seen on the fluoroscopic screen, an impossibility with the radiographic plate.

The two phenomena to which we are about to refer appertain to actions of an organ in a state of movement, and for that reason can only be observed by radioscopy. The first is the heart. Ever since Wells drew attention to the diagnostic value of tachycardia, all specialists and those who devote themselves specially to the study of tuberculosis, have set great store upon this datum, raising it to an important position in the early diagnosis of tuberculosis. One of the most efficient means of verifying this datum is by fluoroscopy. As we never lose sight of this diagnostic resource in our department of tuberculosis, we can affirm, in an indubitable manner, that, with the fluoroscopic screen, the datum of Wells is seen in more than 94 per cent. of cases of tuberculosis, with so much clearness as to remove all doubt on this subject. I shall, moreover, refer to a sign which, I think, has not been touched upon by other authors, namely, that this tachycardia is not rhythmical.

The second example that may be taken for radioscopy, being essentially functional, and one which we have not seen referred to by any other author, appears to our observation with as much, or even more, constancy than tachycardia. We refer to the visibility of the diaphragmatic excursion, both in inspiration and expiration, a phenomenon that, as is easily understood, can be appreciated neither by common means of exploration nor by radiography.

This phenomenon, which under normal conditions is rhythmical and symmetrical on both sides, in tuberculosis is neither rhythmical nor symmetrical. We have observed that in tuberculosis the diaphragm does not rise to the same height on the sick as on the healthy side, and that when the two lungs are affected the ascension is shorter on the worse side; in such manner in the case of a tuberculous patient whose diaphragm on one side has no ascension, or where it is very short, we deduce from this the correspondingly greater or impermeability of the lungs.

*Radiography.*—Accepting also in the case of radiography of tuberculous lungs, as much as we have related respecting the several degrees of transparency and depth of shadows in the first stages, darkness in the tract of the ganglionic and lymphatic vessels, opacity in the congested lung, and very great transparency of the caverns, we shall only say with regard to radiography that it is possible with it to discover the data, also of a certain novelty, in the radiogram of the tuberculous.

In our remarks on tachycardia when dealing with radiography, we said that the heart gives a sign easier of record by radiography than radioscopy. Since the adoption of this valuable means of diagnosis, the small size of the tuberculous heart has attracted our attention, being a true cardiac hypertrophy. If this, as we believe, is a positive indica-

tion of tuberculosis, we shall arrive at a definitive early diagnosis with greater ease if we find in our radioscopic and radiographic explorations small heart, especially if the investigations are accompanied by tachycardia; moreover, we have an explanation of the relations existing between the smallness of the heart, aortic narrowness, and the frequency of tuberculosis in such subjects, which determine the rule existing among these phenomena.

Another datum that may be observed is the peculiar shape of the intercostal spaces. In other works relative to the same matter we have referred to the difficulty of performing percussion on tuberculous patients. The causes of this difficulty are two: the first the extreme narrowness of the intercostal spaces, it being impossible to place the fingers between the ribs, and the second the conical form of the tuberculous thorax. Now before the appearance of the Röntgen method we could hardly understand these difficulties, but since the clinical adoption of this new system, the reasons become apparent. In the radioscopic image is observed a disposition of the ribs strongly resembling the peculiar arrangement of roof tiles, in such a manner that the inferior rib almost touches the anterior face of the inferior rib, the intercostal space being so small, particularly from the fourth rib downwards, that it is difficult to place the finger upon which percussion is made. With radioscopy this disposition of the ribs is very clear, and functional phenomenon corresponding to the diminution of the respiratory excursion in the tuberculous, impossible of diagnosis in any other manner, is very evident.

The transient nature of the radioscopic image, and the necessity of taking it permanently, emphasises the need of closely following with radiography the images described in radioscopy. It is true that radiography cannot give us any information as to function, but in exchange, with this second method, anatomical acts remain permanently indelible, as a book ever open to study.

Among the most interesting facts are deformities of the boxes characteristic of tuberculous thorax. There are in the thorax certain bones, which in their bearing on respiration and also from the muscles that originate from them, are organs of transcendental importance in the osseous respiratory apparatus. They are the clavicle and the scapula. Their position, form and size also produce very important modification in tuberculosis. In taking a radiograph of a tuberculous subject, we see the modifications of these bones; the clavicle principally presents an augmentation on the inflection of its external extremity, and resembling a hyperplasia, but without being sufficient to constitute an alteration of the tuberculous epiphysis, takes the shape of the head of a mace. The scapulae are higher, and the internal and superior vertex is more elevated, swinging towards the centre the point and internal edge which are raised on account of the peculiar disposition of the ribs and spinal column.

Besides these deformities of the skeleton, radiography also shows us the small size of the heart.

The first thing to note is the greater extension of the heart towards the lines of Traube and Friedreich on the right side, this fact showing, in our opinion, a compensatory insufficiency of the tricuspid valve, and, consequently, ventricular hypertrophy on the right side; the radiographic image of the tired heart in tuberculous persons thus acquires a strong resemblance to the image of the tired heart of the emphysematous. The second observation refers to the special form of the heart of tuberculous subjects, similar to the foot of a Chinese woman, in its left ventricular border, bearing in mind the growth of the deformed foot of the Chinese.

*Technique of Radioscopy.*—To observe the phenomena of radioscopy under the best conditions of visibility complete darkness is necessary.

Another trouble that must be got over is the difficulty of applying the fluoroscopic screen, which is commonly rigid and mounted in a frame. In this form the screen can, in tuberculous cases, only be applied upon the sternum or upon the internal edge of the scapula. It is known that in radiographic images size and intensity depend upon the distance between the part under observation and the surface of the screen, so that with rigid screens it is not possible to obtain corresponding equality of definition and intensity over all the surface, and to obtain such a result it is necessary to use a flexible screen mounted on card-board in such a manner that it can be adapted to the convexities of the thorax. One of our colleagues, a very competent person in these matters, Doctor Redondo, Fleet Surgeon of the Spanish Navy, advises the employment in radioscopy, as a radioscopic screen, of the strengthening screen whose image resembles in depth of tone the radiographic image, and gives as fine detail as the ordinary fluoroscopic screen. This application of the strengthening screen makes the solution of the problem easy, because it avoids having to change in the laboratory the fluoroscopic material, of which, as we have said before, the rigid screen is constructed. This modification of the fluoroscopic technique is important in relation to the examination of patients who must have fasted previously in order to obtain with more clearness the semi-lunar space of Traube, and to observe with greater ease the phenomenon of the diaphragmatic excursion previously referred to.

*Radiographical Technique.*—Among the inconveniences attending the use of strengthening screens is the turbid and disseminated nature of the image. When, therefore, we are dealing with images that require great detail, obtained in subjects capable of enduring the exposure—a very short time—that is required to-day to obtain a radiograph, we prefer to work without a strengthening screen in order to obtain a clear image, with richness of detail, especially in pleurisies and patients with but small cavities.

Another interesting subject in radiographical technique, which also gives clearness to the image, and richness of details, is the distance between the tube and the plate. Without discussing theory, but confining ourselves to the collected facts, we have succeeded in fixing this distance at 50 c.c. from the thorax, at which we obtain the maximum richness of detail.

The last matter that will occupy us in this address refers to the development of radiographic plates. We have tried nearly all modern and old-fashioned developers, and we have deduced the necessity of never developing in radiography with ready-made liquids in any uniform proportion, and this applies as much to the developing as to the fixing agents; we use the diamidophenol in 1·2 per 100, with sulphate of soda (crystallised) in 6 per 100 as a developer, and Enckel's (Swiss) hypo-sulphite in 25 per 100. With these products we make our baths as required, that is to say, for two or three radiographs only.

In view of the persistent lack of medical officers for South Africa it is anticipated that the War Office will shortly issue a further appeal for the assistance of civil surgeons. More generous terms will probably have to be offered, however, before any considerable number of qualified men will deem it worth their while to confront the perils and hardships of the campaign. Digitized by Google

## SOME OBSCURE INJURIES FOLLOWING THE TOXIC USE OF ALCOHOL.

By T. D. CROTHERS, M.D.,

Superintendent Walnut Lodge Hospital, Hartford,  
Connecticut.

ALCOHOLIC intoxication is the first cause of many equally serious diseases and neuro-psychoses, although this fact is largely unknown and unrecognised by the profession. The conditions which are traceable to the first toxic action of alcohol may be divided into two classes: 1. The direct injuries which follow from alcoholic poisoning. 2. The psychoses following this state manifested in the alcoholic craze and inebriety which follows.

Persons who become neurotics in the best conditions and surroundings of life and then unexpectedly drink or take drugs to great excess are often found to have a history of some early profound intoxication with slow recovery. These instances are unrecognised, but can be traced in many cases; and the connection between the first intoxication and the later stages can be established without much doubt.

A leading business man became intoxicated at a wedding for the first time in his life, never having used spirits before. He was sick for a week, then recovered. From this time he was conscious of increased nervousness, loss of power of attention, was fearful, and worried about matters which previously gave him no concern. He described his symptoms by the phrase that "he had lost his nerve" and could not control himself as in former times. He complained of weakness and a disinclination to either think or act, and said it all dated from the intoxication at the wedding. This increased until a year later hemiplegia appeared. Two years afterward he died of some acute disease. The interval between the first toxic poisoning was marked by distinct symptoms of both mental and physical changes, and fatal breakdown which have not received any study so far.

Many persons become intoxicated at long, irregular intervals, depending on some unknown causes; and while there are no pronounced symptoms of neuro-psychical disease which attract attention, there are often symptoms of debility and weakness which are overlooked. Such persons suffer from organic and functional disorders and acute diseases that are ascribed to other causes. Neuritis and obscure forms of so-called rheumatism are common. An instance occurred recently of a physician who was seized with what was called an attack of rheumatism, and after a few hours of acute pain died. It appeared that for the past five years he had been intoxicated at least six times, and on each occasion suffered from severe pains in the legs and severe heart depression. The last intoxication was four days before death, and he was out as usual attending to business the day after drinking. No doubt there was some connection between the alcoholic poisoning and the death which was not recognised.

It may be stated as a fact that every intoxication from alcohol is both a physical and psychical concussion to the brain centres and the beginning of both organic and functional changes which may go on rapidly or slowly. Frequent intoxications develop imbecility and masked dementiæ. This is seen from any careful study of chronic inebriates. The resisting power of the brain to continued intoxication varies widely, yet it is evident that after certain changes have taken place the action of spirits may seem less acute and prominent, but the degeneration is continuous. Like repeated blows on the head, the effects are cumulative, and finally merge into well-marked organic neurosis.

The phenomena of intoxication from alcohol are familiar, and yet their physiological and pathological significance is largely unknown. An outline view will be of interest. The first glass of spirits produces a sudden flushing or blanching of the vasomotor circulation of the blood to the face. The facial muscles are first agitated, then become fixed and have a stolid, palsied appearance. Or they may twitch and quiver for a time, then settle down into a stolid, fixed state. The lips seem more firmly compressed, and when used rapidly have a spasmodic movement. The eye appears bright and glittering; then becomes suffused with tears, and rolls about in an unusual way, or settles into a fixed, palsied look. The voice is altered. Words come hurriedly or slowly, or very smoothly glide into each other, both with or without an effort. Respiration is quickened, and a sense of shivering and agitation pervades the body. Brain activity is suddenly increased, rapidly merging into confusional states, with difficulty of utterance. When more spirits are taken all these symptoms deepen. The first shock from a sudden interruption of the normal rhythmical flow of nerve energy passes away and a delusional period follows. This is anæsthesia, with buoyancy, comfort and rest. The first action is that of shock and profound alteration of the functional activities of the brain. Later the special senses become impaired. Sight is diminished. Hearing is dulled. Feeling, taste and smell are lowered. There is a fall in temperature. Muscular power is enfeebled. Memory is weakened. Rapidity of thought and power of concentration, with conception and perception and judgment, are all more or less paralysed. Stupor and unconsciousness follow. Before this later stage a period of exaltation and delusional confidence, inability to think and act more wisely and clearly is nearly always felt. There is in all forms of intoxication first a shock and concussion to the brain and nerve centres. Secondly, a period of anæsthesia of the higher and sense centres, with delusional exaltations and boldness of mind. Thirdly, these all finally merge into stupor, palsy, and unconsciousness. The so-called stimulationis irritation and paralysis.

Psychological measurements of the brain and sense functions as well as the organic functions at their earlier period show palsy. Yet the theory of stimulation is accepted as a true explanation. Each intoxication is a profound sudden paralysis of the brain and nerve function.

A concussion from chemical agents acting in some unknown way, raising the heart's action then lowering it, acts with especial severity on the higher brain centres.

The feeling of comfort, exaltation and superior vigour are delusions. The theory that the action of spirits will give new power and force in an emergency is an error. It brings recklessness and loss of judgment with failure of the finer conceptions of the relations of things, but nothing more.

When alcohol is used to the state of intoxication it is always followed by symptoms which show in some degree the injury which has been done. The common sequela of intoxication are headache and exaggerated sensations of head and stomach, with extreme debility; these are significant signs of injury. The acuteness of these symptoms calls for more spirits, and finally, the suffering subsides because the higher sense centres are blunted and anæsthetised and fail to register the pain impressions.

From our present knowledge of the action of alcohol on the brain and nervous centres, we are sure that recovery from its toxic effects is slow, and in some cases almost impossible. The damage may be covered up and not be clear except from a minute study of the symptoms, and yet it exists.



Intoxication soon after or near the age of puberty has been the starting-point of very serious neuroses which continued years after, often breaking out in some neurosis or form of inebriety.

Profound intoxication at from forty-five to fifty is very serious in the entailments which not unfrequently follow from it.

Some of the facts which I wish to make prominent are these:—

1. Intoxication from alcohol to the extent of coma, with profound relaxation of all the functional activities of the body, is often a serious injury to the brain and nerve centres, and is followed by neuroses and organic change.

2. The significance of alcoholic intoxication in the study of obscure diseases cannot be overstated. It may be both an active and an exciting cause, and should always be considered in neuro-psychopathies or other disorders that follow.

3. Intoxication at puberty and in middle life is often the starting-point of a circle of disease which is usually ascribed to other causes.

4. Intoxication always predisposes to the diseases of inebriety from alcohol or opium, which may come on suddenly at any time in after life.

5. Poisoning from alcohol is far more serious than supposed, both in its effects and the neuroses which follow.

## An Address (a)

DELIVERED BY SIR CHRISTOPHER NIXON, M.D.,  
President of the Royal College of Physicians, Ireland.  
PUBLIC HEALTH.

AFTER some introductory remarks, the speaker said that when on a previous similar occasion he had delivered an address, he referred briefly to the important question of public health with a view of pointing out the opportunities which this branch of medicine afforded to those who devoted themselves to it and mastered the subjects required for the diploma in public health. He then took a somewhat sanguine view of the changes that were likely to be effected in Ireland in the various urban and rural districts in the appointment of medical officers of health, who would be obliged to devote themselves, as in England, exclusively to their special duties, with the result that the sanitary conditions of the poor should be improved, the spread of disease lessened, the death-rate diminished, and the burthens on the taxpayer reduced. It seemed as if we were on the point of taking a lesson from the sister country, and that the administration of public health laws in Ireland were to be assimilated to what obtains in the urban and rural districts of England. The Local Government Board issued an order requiring the appointment of medical officers of health for a union, or combination of unions in Ireland, but, so far as he could learn, the order has been a dead letter, and the condition of things continue as bad as they have been. Nor can it be said that the attempt at public health reform in the provinces has been surpassed by what has been done in reference to our own city. On February 13th, 1900, a committee appointed by the Local Government Board to inquire into the public health of the city of Dublin, held its first meeting. After taking a considerable amount of valuable evidence, the committee, with commendable promptitude, presented its report. Among many important recommendations of the committee were—that the duties of Medical Officer of Health should no longer be discharged by the sixteen Dispensary Medical Officers, and that in future those duties should be discharged by an Assistant Medical Officer of Health who should receive an adequate salary and give his whole time to the duties of his office. A second recommendation of most vital importance to the community of this large city was that a hospital should be provided for the treatment of small pox at a distance from populous neighbourhoods. Up to the

present neither of these regulations have been acted upon, nor is there any indication that he knew of to show that they will, in the near future, be carried into effect. At any time cases of such diseases as small-pox or plague might find their way to the city, and no provision whatever exists for their isolation. It reflects not a little credit upon the Superintendent Medical Officer of Health that, considering the many avenues which exist in a large city like Dublin for the entrance of cases of infectious diseases, neither small-pox nor plague has appeared in our midst. It is scarcely possible, in this connection, to avoid urging upon those responsible for the health of Dublin to take steps to put the city on a level with what has been done in reference to the recognition of infectious diseases in the chief cities of England and Scotland. Take, for example, the arrangements existing in Manchester, Liverpool, Edinburgh, and Glasgow. In all, a special laboratory is provided, and the services of a municipal bacteriologist are secured, whose work embraces the examination of foods, water, effluents of all kinds, outbreaks of typhoid fever, scarlatina, diphtheria, cholera, plague, &c. Examinations are made gratuitously for medical practitioners who send to the laboratory specimens for analysis in cases of suspected diphtheria, enteric fever, tuberculosis, milk for tubercle, &c.; and facilities are afforded by which the specimens are examined and the diagnostic results furnished with the utmost expedition. It is, surely, not too much to expect that Dublin should not lag behind when such progress is being made in England and Scotland. The present time is singularly opportune for a move in this direction. Last year, in a short address which he delivered on the relation of veterinary science to human medicine, he ventured to suggest that we should follow the example set to us by establishing in Dublin an institute similar to the Jenner Institute in London, which received from Lord Iveagh the munificent donation of a quarter of a million. Sir George Duffy took up the matter most warmly, and he and a representative Committee have formulated a scheme for the foundation and organisation of an Institute of Research and Public Health, which upon its merits will, he (Sir Christopher) trusted, elicit generous and sympathetic support. There is one point in connection with the proposed Institute which he would like to emphasise. Considerable sums of money are often wasted, especially in departments of the State, by no efforts being made to concentrate works of a kindred nature being carried out in a single institution. The result is often multiplicity in the cost of management, of office expenses, of duplication of offices, &c. This should be carefully guarded against. To mention an instance in point. A clause was introduced into the English Lunacy Acts Amendment Bill, extending the power of two or more local authorities, in providing and maintaining a district asylum, so as to include a power to agree to unite in providing and maintaining a laboratory for pathological research in connection with lunacy. This year a Bill was passed assimilating the provisions of the Irish Lunacy Acts in this respect to what obtains in England, so that the Asylum Boards throughout the country have the power of establishing a laboratory for research in connection with mental and nervous diseases. It is to be hoped that this laboratory will form a part of the National Institute, so that every resource available may be employed to render it in all respects worthy of its object and creditable to the country.

### THE COLLEGES AND THE GENERAL MEDICAL COUNCIL.

There is one other matter which he might bring under notice. It is in reference to the contention between the two Royal Colleges in England and the General Medical Council as to the subjects of the medical curriculum. The Royal Colleges, as you may be aware, recognise instruction in chemistry, physics, and biology given in certain intermediate schools as in all respects equivalent to the courses given in medical schools, though in the latter requirements as to number of lectures, certificates, &c., must be complied with. The Royal Colleges contend that they fulfil the requirements of the General Medical Council in making it necessary that five years should elapse from the time of registration as a medical student

(a) Delivered at the Distribution of Prizes at the Catholic University School of Medicine, Dublin, on Nov. 23rd.

until the candidate presents himself for his final examination, so that there is on their part no whittling down of the time limit recommended by the Council. On the other hand, it is contended that the acceptance of instruction in what have been regarded as subjects of the Medical Curriculum, from what are called Grammar Schools, really reduces the Medical School course to four years, and that thus the regulation practically means a return to the four years' curriculum. This contention, he confessed, he had been unable to follow. The teaching of physics, or of botany and zoology, cannot be sufficiently specialised, no matter where taught, to make them medical subjects. These subjects, as well as chemistry, are taught in the Universities as parts of their Arts and Science Departments, so no case can be made as to regarding them as medical subjects. If this be conceded the issue is narrowed to this point:—Is there any advantage to be gained by requiring special courses of lectures to be given in physics, chemistry, and biology in Medical Schools alone? The answer to this question may be taken as only involving the case of students presenting themselves for the examinations of the licensing bodies, as he assumed the Universities will always require the higher standard of education and perhaps curriculum. But, taking the case of students who are preparing for the examinations of the licensing bodies, is the regulation requiring special courses in medical schools in physics, elementary chemistry, botany, and zoology, a necessary and useful one? No one is prepared to concede more than he did the necessity for medical students having a high and broad degree of general culture before commencing

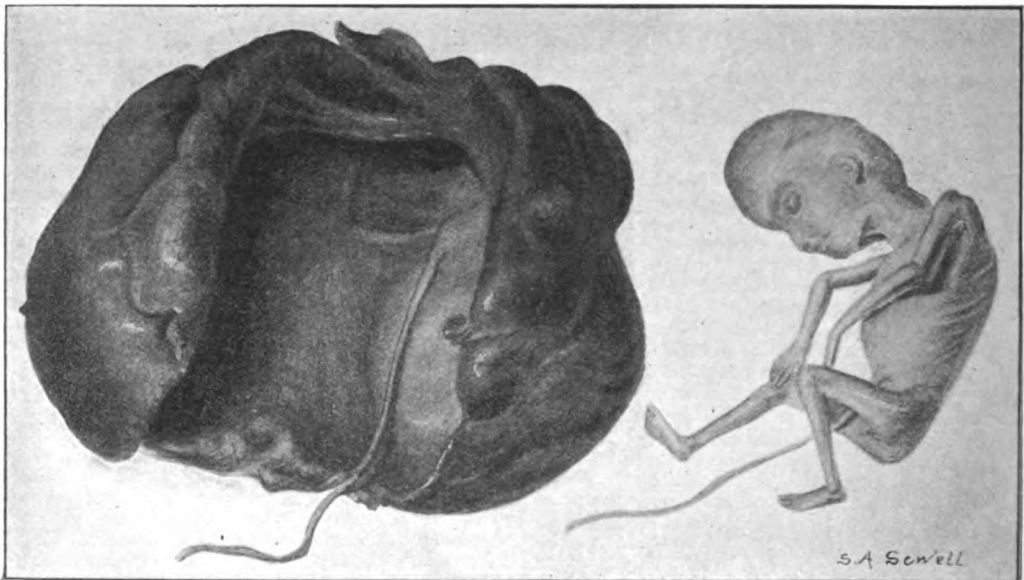
of technical knowledge which will enable him to become a safe and skilful practitioner.

### Clinical Records.

#### CASE OF ECTOPIC GESTATION WITH ESCAPE OF GESTATION SAC INTO THE PERITONEAL CAVITY. (a).

Under the care of Dr. MACNAUGHTON-JONES.

THE patient, *æt.* 33, had been married for upwards of four years; there had been no previous conception. A year previously she had been treated for an erosion of the cervix. The last menstrual period occurred eleven weeks before the onset of her illness, which was on July 10th, when she was seized with acute pain in the abdomen, and sickness, the consequences, as she thought, of a chill taken the same day. The pain was relieved by rest and sedatives, recurring, however, periodically. As ectopic gestation was feared, she was kept in bed and under observation. On the 15th there was a recurrence of the symptoms, followed by greater prostration, but no uterine hæmorrhage. Again she appeared to get better, but on the 24th violent abdominal pains set in, the pulse became very rapid, and the face blanched; I saw her for the first time, in this condition, late the same evening. The abdomen was tumid and dull on percussion, the uterus fixed, and the pouch of Douglas occupied by a resistant swelling. Early the following morning I operated. She had rallied somewhat from her condition of the previous evening, but



ILLUSTRATING DR. MACNAUGHTON-JONES' CASE.—SHOWING SAC OPEN—THE SURFACE WITH ADHESIONS IS NOT SEEN.

the study of medicine. He must, however, frankly confess that, whatever one may think of the course taken by the Royal Colleges in connection with the General Medical Council, as that course simply was dictated by the inflexible determination of the college not to accede to the Council's requirement of their approval of the institutions recognised by the colleges, he believed the latter are in the right. The subjects of the first year are really not subjects of medical education. They can, he believed, be quite efficiently taught in schools properly equipped and recognised for the purpose of teaching after being duly inspected. The student having passed a sufficiently searching examination in those subjects enters upon his course of medical studies perfectly free to devote himself for four years to the subjects laid down in the curriculum. Two of these years should be devoted mainly to the scientific branches of medicine, whilst the remaining two years should be exclusively spent in those branches

still the pulse was weak and fluttering, and the lips quite blanched.

On opening the abdomen I found the cavity filled with blood. This, with masses of soft coagula, was removed. I quickly came on the gestation sac about the level of the umbilicus, with the placenta, the mass being adherent to the bowel. It bled freely. The hæmorrhage was controlled digitally, and I still found blood welling up in quantity from the pelvis. I soon found that the bleeding was proceeding from a large rent in the left broad ligament, running close up to the uterus. This was quickly stopped by the application of two long Doyen's clamps running at either side of the rent. The gestation mass was then removed, the adhesions being separated, and any bleeding points ligatured. Ligatures were then passed at either side of the clamps with

(a) Notes of the case read and specimens shown at the meeting of the British Gynaecological Association, November 14th, 1901.

Deschamp's needles, and the broad ligament secured. Up to this I had not seen the fetus, and failed to find it until I passed my hand up under the diaphragm, where I found it in the left hypochondrium. There was no further bleeding and the abdomen was closed. Saline submammary injections had been administered during the latter part of the operation, and were continued throughout the day, with rectal stimulating enemata. She rallied for some hours after the operation, but never recovered from the collapse, surviving only nineteen hours. Her surroundings were not the most propitious for recovery, though her medical attendant left nothing undone to secure it.

## Transactions of Societies.

### CLINICAL SOCIETY OF LONDON.

MEETING HELD FRIDAY, NOVEMBER 22ND, 1901.

MR. HOWARD MARSH, F.R.C.S., President, in the Chair.

MR. T. H. MORSE ON

#### TWO CASES OF INTRACRANIAL SECTION OF THE SECOND AND THIRD DIVISIONS OF THE TRIGEMINAL NERVE FOR SEVERE NEURALGIA.

Reference was made to the articles published by Mr. Victor Horsley in 1891, those of Mr. Rose in 1892, also to those of Hartley, Krause, Jonathan Hutchinson, jun., and Lynn Thomas. Two cases were related in which the Hartley-Krause operation was performed, the bone being removed with mallet and gouge, and gouge cutting forceps. After section of the second and third divisions of the fifth nerve the foramina ovale and rotundum were blocked with Horsley's wax for the purpose of preventing reunion of the divided nerves. In both cases cure was obtained, the first having been done more than two years ago.

Mr. J. HUTCHINSON, JUNR., showed four cases in which he had performed this operation, the last only six weeks since, so far with complete relief. In another case, operated four years ago, the patient had previously undergone several operations comprising division of nerves, &c., and, lastly, an operation in which Meckel's ganglion was removed. Case 3 had suffered for many years, and in this case the Gasserian ganglion was removed by Krause's method with success. The last case was one in which the neuralgia had spread to the occipital region. Krause's operation was done and the ganglion removed, together with the two lower branches of the fifth nerve behind the ganglion. Thereupon the occipital pain also subsided, showing that it was reflected pain. In none of these cases had there been a return of the pain. He preferred the temporal operation in preference to operations through the pterygoid region. The advantages of removing only the lower portion of the ganglion were (1) the cavernous sinus was not interfered with; (2) there was no danger of injuring the oculo-motor nerves; (3) there was no need to tie the middle meningeal artery, and (4) there was no anæsthesia of the cornea, although with regard to this point Horsley had stated that any damage to the cornea could be avoided by careful attention to antisepsis and sewing up the eyelids immediately after the operation. He, however, quoted a case in which he had divided the ophthalmic branch of the fifth nerve, followed by corneal anæsthesia. Some months later ulceration set in and eventually the eye had to be removed; (5) neuralgia as a rule does not occur in the ophthalmic branch of the fifth nerve. He did not think that it was necessary to make a large flap. In only one case did he have to tie the external carotid on account of hæmorrhage. With regard to the position of the patient he much preferred that of sitting erect in a chair, whatever the anæsthetist might say. He pointed out that the ganglion could not be effectually removed by means of the curette, but should be cleanly cut out. Estimates of the mortality from the operation varied from 20 to 50 per cent., but in this country, at any rate, he did not

believe that the mortality exceeded 10 per cent. He himself had done five cases without a death. He condemned very strongly Doyen's method of operating, which entailed an unnecessarily extensive operation. He protested against the modifications of the operation being tacked on to the names of various surgeons, which produced a feeling of bewilderment. He advised that the major operation should not be postponed too long; in fact, whenever the pain was above the superior maxillary branch, only the major operation could be trusted to afford permanent relief.

Mr. CUTHBERT WALLACE mentioned a case in which he was much embarrassed by the bleeding from a wound of the cavernous sinus. With regard to the choice of operation he observed that this must be decided by results. He had heard it said that the temporal operation had already fallen into disrepute in America.

Mr. BALLANCE said he had performed the operation ten times. In two of the cases he had removed the whole of the ganglion, pulling out the nerve beyond the ganglion on the proximal side. He did not think there was any difficulty in isolating the ganglion, the risk to the patient lying in the length of time it took, and the hæmorrhage. The hæmorrhage, however, would never alarm them if they were prepared for it. The best preparation for the operation was careful study on the dead body. The more they studied the details the easier it became. No age was too advanced for this operation; two of his patients were sixty-four and seventy-one. He advocated performing the operation in several stages, thus avoiding shock. He did not believe that relief was likely to follow partial operations. He himself had removed a quarter of an inch of the first division in the wall of the cavernous sinus. He had never seen any cerebro-spinal fluid escape. By gentle traction one could get half an inch of the main nerve trunk from behind the ganglion. All operations from the pterygoid region ought to be banished from their repertoire. He anticipated that the time would come when they would cease to raise the dura mater from the middle fossa to get at the ganglion, and he hoped that it would become possible to divide the sensory part of the nerve without touching the motor part. In reply to a question by Mr. Lucas, he said that he had ceased to replace the piece of bone removed, and Mr. Hutchinson replied that he did not replace it.

#### MR. WARRINGTON HAWARD ON A CASE OF FRAGILITAS OSIUM.

A boy, æt. 10, was admitted into St. George's Hospital, under Mr. Haward's care, in October, 1889, on account of extreme deformity of the legs. He was a bright, intelligent, and healthy-looking boy, with no signs of rickets. He sat upright, and his spine was straight. The bones of the arms and forearms were then bent and were curved outwards to a varying extent. They showed signs of many old fractures. The hands were fairly developed and were used actively. The lower limbs were less developed than the upper. The bones were thin, and with sharp margins. The femora were both curved forwards and outwards. [The tibiae both showed an extreme degree of forward curvature, so that the lower half was at a right angle to the upper half of the leg. There was evidence of numerous past fractures. The muscles of the legs were much wasted, and the skin was adherent over the most prominent part of the tibia. Photographs of the boy and skiagraphs of the bones were shown. The boy's health appeared in most respects to be good, with the exception of a remarkable condition of the urine. The urine when passed appeared natural, but on standing deposited a large amount of calcium salts, which formed a mortar-like sediment. An analysis of the urine kindly made by Mr. J. A. Gardner showed it to contain a very large excess of lime salts. The history of the case told that the boy was of healthy parentage, and that of eight children none but this boy showed any signs of disease. The only notable point in the family history was that before the birth of this child (the seventh) the mother had been weakened by rapidly succeeding pregnancies. When born this child was found to have fractures of both humeri and two

ribs, and subsequently twenty-three fractures of long-bones were recorded, all from slight causes. He had never walked alone. He had lived in a healthy part of the country, and had been well fed and cared for. He was given, after admission to the hospital, cod-liver oil, and a highly nutritious diet, and attempts were made to straighten the limbs by extension, but without success. In January, 1900, he fractured the left femur when turning in bed, but the bone united well under ordinary treatment. In March, an analysis of the urine by Mr. Gardner having shown that the excessive excretion of lime salts had ceased, Mr. Haward straightened the right leg by the excision of a wedge-shaped piece of the tibia, the ends of the bone being wired together. The bones united soundly. The left leg was subsequently operated upon with similar result, and the boy was sent home with leather splints on. He is now learning to walk. Reference was made to a similar case recorded by Mr. Clinton Dent, and the paper concluded with some remarks upon the connection of the bone changes with the condition of the urine.

Mr. CLINTON DENT showed photographs and skiagrams of a case of the kind which he had brought before the Medical Society some years since, the subject being a man, *æt.* 29. He mentioned that the fractures were preceded by pain in the spot, and the throwing out of a plastic callus.

Dr. POINTON referred to a case in a breast-fed infant whom he had seen at the Hospital for Sick Children in which fracture was always preceded by tenderness and pain in the shaft, and not in the epiphysis. There was no history of syphilis in this case.

Mr. HUTCHINSON, junr., mentioned a case of the kind in a child, the subject of inherited syphilis, but he was not prepared to assert that this was more than a coincidence.

Mr. LUCAS insisted on the importance of clearing up the influence of inherited syphilis in these cases.

Mr. HAWARD, in reply, said he could offer no explanation of the cause of this curious form of malnutrition, but it was certainly not syphilis. In his case there was never any tenderness of the bones.

## ROYAL ACADEMY OF MEDICINE IN IRELAND.

### SECTION OF MEDICINE.

Held in the Royal College of Physicians, FRIDAY EVENING, Nov. 15TH, 1901.

OWING to the unavoidable absence of Sir Christopher Nixon, M.D., President, the chair was taken by Dr. JAMES LITTLE.

Dr. FINNY read the notes of a case of

#### DERMATITIS GANGRENOZA,

which occurred in a child, *æt.* 2½, who died in Sir Patrick Dun's Hospital, five days after admission, in May, 1900. The child was extremely prostrate on admission, his back, thighs, penis, hands, face, scalp, ears, forehead and eyelids were the seat of circular punched out sores, varying in size from that of a threepenny bit to that of half-a-crown, more or less covered with a yellowish-green pultaceous scab. After poulticing with boracic acid the ulcers were clean, smooth, with sharply defined edges of a deep, raw meat colour. There were no bullæ visible anywhere, nor any sign of varicella; and vaccination had been performed two years and a-half before. There was no history of syphilis. On inquiring he found the child had not been in contact with any contagious disease. The Registrar-General stated that there was no chicken-pox in Dublin, or in Ireland (except in a distant part of Donegal) at that time. The post-mortem examination revealed caseating tuberculosis of the thymus gland, lungs, and bronchial and mesenteric glands. Before admission to hospital the child had been seen three times by Dr. W. Beatty, who noted it as a case of impetigo, which rapidly was converted into gangrenous sores. The eyes were in a state of pan-ophthalmitis. Dr. Finny considered it a typical extreme example of the rare disease originally described by Dr. Whitley Stokes, in Ireland, in 1807, as "eating hives," "white blisters," or "pemphigus gangrenosus,"

and subsequently graphically depicted by Jonathan Hutchinson, in 1879 and 1882, under the name of "varicella or varaccinia gangrenosa," a designation adopted by most writers since then. Dr. Finny, however, preferred the more comprehensive title "dermatitis gangrenosa" given by Dr. Croker. Discussing the ætiology, he considered the disease to be due to some special microbic infection attacking children suffering from some pustular disease. One of the hands affected by the disease and photographs of the child were exhibited.

Dr. WALLACE BEATTY never met with an identical case to the one described, though he met with a curious form of impetigo, in which the pustules were, though discrete, close. They were unhealthy looking, exuded a glairy secretion, and had a dark base. In a case of injury to the hand a rash resembling impetigo appeared, and was followed by ulceration.

Dr. CHARLES MOORE, some forty years ago had a number of such cases as those described by Dr. Finny under his care in Cork Street fever hospital. From the appearance of the gangrenous sore they were called "burnt holes."

Dr. WALTER SMITH looks upon gangrene as a much less common occurrence than reasonably might be expected. Gangrene occurs under so many conditions; mechanical, thermal, and so forth. Mere arterial constriction is not sufficient to account for gangrene following the use of ergot. It is due to poisons from within and poisons from without falling on suitable soil, hence the occurrence of gangrene in diabetic patients, hospital gangrene, acute gangrene in nervous diseases, acute bedsores of Charcot in hemiplegia, more common in left side hemiplegia, in syringomyelia. The ætiology of necrosis is as yet imperfectly understood.

Dr. L. STAMES, whilst acting as registrar to Sir Thomas Barlow, saw two cases similar to that described; they occurred in girls between six and seven years of age. The ulcers gave out a thick, viscid, glycerine-like discharge. One case that died was tuberculous. He, in up the literature of the disease, found that it was looking described by an Irishman whose name he could not remember, and was called "burnt holes."

Dr. McWENEY found some two years ago when making an autopsy on a patient who had died of typhoid some of the gangrenous holes they had heard of, there were some half-dozen of the "burnt-holes." He examined them, sectioned them, and made some cultivations, of which on a future occasion he hoped to detail the results to the Academy. On the surface of the skin he found numerous cocci, but these cocci had nothing to do with the ulcer, which was due to a minute bacillus in the deeper tissue, which by cultivation gave a similar bacillus like to that of *cancrem oris*. He did not notice any bullæ on the subject he examined.

Sir JOHN W. MOORE said the case he embodied in his work on continued fevers was not due to varicella gangrenosa, its ætiology was to be found in bacterial thrombosis.

Dr. BURGESS, who had known the patient of the late Sir W. Stokes, said there were two gluteal ulcers of large size, like to the cavity of a carbuncle.

Dr. KNOTT drew attention to the frequency of "burnt holes" during the famine years. He looked upon the disease as closely related to "noma." The inflammation of the eyes in Dr. Finny's case he considered to be the outcome of nutritional changes.

Dr. JAMES LITTLE thought that all the cases to which reference had been made could not be included under the same class as that of Dr. Finny's patient. The case was an extremely rare one, and he was sure they all felt grateful to Dr. Finny for bringing it before them. Some of them told of recoveries, but he thought it was too much to expect recovery in such a tuberculous patient, and Dr. FINNY replied.

Dr. CONNOLLY NORMAN read a report of a case of

#### PARANOIA HALLUCINATORIA.

The case was of interest as presenting a form of tactile hallucination not heretofore described, and also unilateral auditory hallucinations (both common and verbal) heard in the right ear. The patient suffered

from absolute deafness of the right ear, due either to auditory nerve or labyrinthine disease. Hallucinations of the other senses were bilateral. The tactile hallucination consisted in a sensation of the finger tips as if they were dry and polished. This sensation Dr. Norman compared to that which is produced by the ingestion of belladonna. In mentioning that this patient exhibited, together with other true gustatory hallucinations, an hallucination of the flavour of alum, the author claimed that to the four sensations commonly recognised as the only true gustatory feelings, namely, sweet, sour, bitter, and salt, there should be added the sense of astringency (such as occurred in the form of hallucination in this case), and probably also the sense of pungency. Incidentally Dr. Norman also claimed a special position for the sensations connected with the respiratory functions, a group of sensations often concerned in hallucinatory states, as occurred in the case reported upon.

Dr. DAWSON desired to hear from Dr. Norman if the hearing was lost before or after the auditory hallucinations commenced. The delusive interpretations of the senses was one of the most frequent phenomenon of insanity. One of his patients, hearing a railway whistle, answered as if the sound were a voice. Dr. Norman's case was peculiarly interesting from the number of special senses implicated and the fact that the auditory hallucinations were unilateral. In a case of early general paralysis in a patient he examined the delusive interpretation of the visual sense was well marked. At first as the cornea became clouded the patient saw moss, finally devils, monkeys, and ultimately declared that a hospital had been built at the back of his eyes to blind him.

Dr. WALTER SMITH would like to know if auditory hallucinations were not the most commonly met with. Special sense hallucinations following the toxic action of certain drugs are deeply interesting in this connection: the visual hallucinations of acute alcoholism, and the auditory hallucinations that occur so early in cocaine poisoning are examples known to all.

Dr. BEWLEY, referring to auditory hallucinations, told of a deaf patient who heard voices upbraiding him for crimes committed in youth. Ignorance is a fruitful source of misinterpretation. Children afraid of darkness. The insane hallucinations often arise from attempts to interpret sounds that the sane ignore.

Dr. NORMAN replied, and the Section then adjourned.

#### BRITISH GYNÆCOLOGICAL SOCIETY.

MEETING HELD NOV. 14TH, 1901.

The President, J. A. MANSELL MOULLIN, M.A., M.R.C.P., in the Chair.

#### EXHIBITION OF SPECIMENS.

Dr. FREDERICK EDGE (Wolverhampton) showed the following specimens:—

I. *Ruptured Tubal Gestation*.—The interesting features of the case were that the tube was adherent, and that the mass being situated in the neighbourhood of the appendix the symptoms seemed to point to appendicitis. On operating, however, the case proved to be one of simple tubal gestation, the appendix not being involved.

II. *Myoma*.—In showing this specimen, Dr. Edge remarked that while theoretically he was a strong supporter of pan-hysterectomy, he had gradually become impressed with the simplicity of the supra-vaginal operation, and the very satisfactory results which followed its performance. It was by the supra-vaginal method he removed the specimen exhibited.

III. *Uterus Removed by Vaginal Hysterectomy for the relief of Prolapse*.—Two years previously he had performed plastic operations on the vagina which were not attended with the desired result. The patient having passed the child-bearing period, he performed vaginal hysterectomy. He drew attention to the fact that a certain amount of vaginal mucous membrane was attached to the cervix. Modifying the procedure adopted by Mr. Christopher Martin, who dissects the

vaginal mucous membrane from the subjacent structures, before performing hysterectomy, he had performed anterior and posterior cœliotomy, brought the fundus out, ligatured the uterus from above down, and divided the cervix. He then finds it an easy matter to strap the vaginal mucous membrane down as far as necessary, and contends that hæmorrhage is more fully controlled, and that there is greater expedition than when the dissection is done from below up.

Dr. HEYWOOD SMITH advocated supra-vaginal hysterectomy, and Dr. MACNAUGHTON-JONES referred to the importance of examining the appendix before closing the abdomen in every case of laparotomy.

Mr. O'CALLAGHAN showed the appendages of a patient, æt. 26, which had been removed for double pyo-salpinx. There were hæmato cysts in the right ovary. The disease was traceable to the gonococcus. He also showed a myoma enucleated from the anterior wall of the uterus by cœliotomy, and another myomatous tumour removed by hysterectomy. All three cases made good recoveries.

Mr. JESSETT and Dr. HEYWOOD SMITH questioned the propriety of removing the ovaries when healthy, and Dr. MACNAUGHTON-JONES thought that the plan of leaving one ovary was the more prudent to adopt.

#### PROPHYLAXIS IN GYNÆCOLOGY.

Dr. SNOW, in his paper, dwelt on the evil effects of the corset in inducing pelvic anomalies, referring specially to its influence in promoting the development of myomata, noting the fact that in primitive peoples myoma was very rare. Its tendency to cause backward displacements was dwelt on. Among other prophylactic precautions advocated was a more close and active attention to habitual constipation, while the evil consequences following on too frequent pregnancies was considered.

#### USE OF ARTIFICIAL SERUM IN PROLONGED OPERATION.

Dr. MACNAUGHTON-JONES showed the adnexa of a patient, æt. 40. Some short time before operation she had been curetted, and a polypus removed from the uterus. There had been a history of pelvic pain extending over seventeen years, since her last pregnancy. Before operation she suffered from intense pain, frequent fainting fits, and symptoms of collapse. At the operation the inlet of the pelvis was discovered to be completely closed by a smooth and firm plastic bed, completely obscuring the adnexa. On breaking this down, the latter were found to be converted into thickened, adherent, and enlarged tubes with old pus sacs, the ovaries also being enlarged and cystic, with purulent infiltrations. Their removal was extremely difficult. As one pus sac ruptured an iodoform drain was left in, and this was finally removed on the fourth day. The recovery of the patient was uneventful. The case, with one recently exhibited, well illustrated the danger of temporising with such adnexal conditions, which often necessitated the performance of an operation far more difficult and prolonged than any ordinary hysterectomy. In this particular instance, save for the use of artificial serum, it is doubtful if the operation (the entire duration of which was close on two hours) could have been completed.

Dr. MACNAUGHTON-JONES also read notes of a case of "Ectopic Gestation with Escape of Gestation Sac into the Peritoneal Cavity." This will be found in another column under the head of "Clinical Records."

#### LARYNGOLOGICAL SOCIETY OF LONDON.

MEETING HELD NOV. 1ST, 1901.

E. CRESSWELL BABER, M.B., President, in the Chair.

#### CASES.

Mr. W. G. SPENCER showed a case of tertiary syphilitic laryngeal stenosis treated by laryngo-fissure without tracheotomy, the result of which was most satisfactory; there was no dyspnoea, and the patient had quite an audible voice.

Mr. WESTMACOTT showed a series of specimens, photo-

graphs, and drawings illustrating the inflammatory diseases of the nose and accessory cavities.

Dr. HERBERT TILLEY showed two molar teeth in which the crowns were healthy but in which there was evidence of suppuration about the palatal roots; the patients from whom they were extracted both suffered from disease of the corresponding maxillary antrum.

Dr. J. DONELAN showed a case of laryngeal syphilis with fixation of the left vocal cord in a man, *æt.* 52, and raised the question as to whether it was not malignant as well as syphilitic.

Dr. ST. CLAIR THOMSON showed a man, *æt.* 33, who had been brought before the Society in April last with chronic laryngitis and an ulcer on one vocal cord, who now presented marked lupus infiltration and ulceration of the epiglottis.

Dr. E. WAGGETT showed a case of (?) congenital fenestration of the anterior pillars of the fauces. Many such cases had been shown at the Society, and much discussion had taken place as to whether they were of congenital origin or the result of scarlet fever.

Dr. CLIFFORD BEALE said that since the last case of this sort was shown he had made inquiries at the fever hospitals, and had learned that fenestration as the result of scarlet fever was practically unknown.

Mr. ST. GEORGE REID showed a series of living cultures of those bacilli which simulate the bacillus tuberculosis by staining reactions.

Dr. FITZGERALD POWELL showed a case of papilloma of the larynx, which was peculiar in being of an almost pure white appearance.

Dr. DUNDAS GRANT showed a case of epithelioma of the epiglottis. The operative treatment of such cases was discussed by Mr. H. T. Butlin and Dr. H. L. Lack.

Dr. DUNDAS GRANT also showed a case of nasal stenosis, in which the symptoms appeared to be chiefly subjective.

Mr. H. M. RAMSAY showed a case of (?) tuberculous disease of the epiglottis. It was thought to be lupus, and suitable for treatment.

Dr. J. W. BOND showed a case of swelling of the left ventricular band in a boy, *æt.* 14.

#### SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

MEETING HELD (Rooms of the Medical Society of London), Nov. 15TH, 1901.

Mr. ROBERT JONES, of Liverpool, occupying the Chair.

#### CASES.

Dr. DAVID WALSH showed a girl, *æt.* 14, with a tumour in the left flank diagnosed as hydronephrosis. An X-ray examination of the case showed a small calculus impacted in the ureter near the bladder, and also a hydronephrosis shadow.

Mr. E. CLEMENT LUCAS suggested that before operation was resorted to the patient should be examined *per vaginam* under a general anæsthetic.

Mr. SYDNEY STEPHENSON exhibited a child, seventeen months of age, who was suffering from acute miliary tuberculosis, with pulmonary and cerebral manifestations. Double optic pupillitis existed, and a typical tubercle was present in the choroid coat of the right eye. There was, in addition, a tuberculous ulcer involving the palpebral conjunctiva of one eye. The ulcer (in scrapings from which tubercle bacilli had been demonstrated) had destroyed a portion of the free edge of the eyelid, and was not associated with granulations.

Mr. GEORGE PERRET thought the conjunctival ulceration corresponded to the miliary tuberculous ulcer occurring sometimes about the edges of the lip.

Dr. C. O. HAWTHORNE remarked that the optic discs were considerably swollen, and suggested that the pupillitis might possibly be due to a tuberculous intra-cranial tumour, and not to tuberculous meningitis.

Dr. C. O. HAWTHORNE showed a boy, *æt.* 6, with considerable enlargement of the lymphatic glands of the neck, with a similar but less marked condition of the axillary glands. The blood showed no excess of white corpuscles, but a relative increase of lymphocytes. He considered the case to be one of Hodgkin's disease.

Dr. A. E. SANSON asked whether the spleen was enlarged?

Dr. B. HUTCHISON suggested that the case was one of tuberculous glands. He doubted whether there was really such an affection as Hodgkin's disease.

Mr. Perret and Mr. B. Clement Lucas also discussed the case.

Dr. HAWTHORNE, in reply, said the lower end of the spleen could be felt. He pointed out that the glands were not matted together, and that their characteristics were different from those of tuberculous glands.

Dr. G. A. SUTHERLAND and Mr. JACKSON CLARKE showed a child, *æt.* 2, with marked shortening of all the limbs, six digits on each hand, slight hare-lip, and congenital heart disease. They suggested that an achondroplastic condition was present.

The case was discussed by Dr. Hutchison, Mr. Perret, and Dr. Shuttleworth, and Dr. SUTHERLAND briefly replied.

Dr. EDMUND CAUTLEY showed the heart of a child, *æt.* 15, who died from pulmonary regurgitation. The specimen weighed 11 ozs., and was firm and globular. The right ventricle was markedly hypertrophied. The pulmonary valves were much thickened and puckered, and on two of them were warty vegetations with apparent loss of substance.

Dr. THEODORE FISHER thought the case one of infective endocarditis, a view shared by Dr. A. E. Sanson, and Dr. CAUTLEY replied.

Mr. GIFFORD NASH (Bedford) showed the kidneys from two children of the same family whose ages were six months and ten weeks respectively. The kidneys were the seat of congenital cystic degeneration, and the enlargement in each case was noticed shortly after birth.

Dr. THEODORE FISHER inquired whether it is common for children with congenital cystic kidneys to live weeks or months?

Mr. NASH, in reply, said there were instances on record of such patients surviving to twenty or thirty years of age.

Mr. J. HOWSON RAY (Manchester) showed specimens and sketch illustrating a case of congenital umbilical hernia of the size of a fetal head occurring in the Children's Hospital, Manchester.

Dr. EDMUND CAUTLEY read a paper on the

#### ETIOLOGY AND MORBID ANATOMY OF TUBERCULOUS MENINGITIS,

based upon the post-mortems and clinical records of the last twenty-seven fatal cases under his care. Twenty-two occurred in children under five years of age, and only five during the next five years of life. A family predisposition existed in five cases. In two instances only was disease limited to the meninges. In twenty-three the mediastinal glands were caseous, and in four of these the mesenteric glands were also affected. Dr. Cautley summed up his views shortly as follows:—Heredity means exposure to infection. Injury is rarely an exciting or predisposing cause. The respiratory tract is the great channel of infection. The alimentary tract is rarely primarily infected. Tuberculous milk is rarely, if ever, the source of infection. The prognosis is very hopeless on account of the extent of the tuberculous disease elsewhere. The evidence obtained from the examination of the brain shows that operative treatment may be discarded as experimental rather than useful.

The paper was discussed by Dr. G. A. Sutherland, Dr. Theodore Fisher, and Dr. Willmer Phillips.

#### SHEFFIELD MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD Nov. 7TH, 1901.

The President, Dr. C. H. WILLEY, in the Chair.

#### CASES.

Dr. J. H. KEELING related two cases of abdominal hysterectomy, and showed specimens.

Dr. D. BURGESS showed specimens from (1) a case of Addison's disease in a boy, *æt.* 9; (2) a case of granular

contracted kidney in a boy, *æt.* 16, a plumber, who had suffered from lead poisoning.

Dr. A. J. HALL showed a simple method for the clinical estimation of hæmoglobin.

Mr. A. M. CONNELL showed specimens from the following cases: (1) abdominal nephrectomy for sarcoma; (2) lumbar nephrectomy for tubercle.

Dr. C. N. GWYNNE showed a case of congenital dilatation of the sigmoid flexure of the colon. The boy, *æt.* 16½, had been subject from birth to an aggravated form of chronic constipation. Of late years his abdomen had been much enlarged, and before admission had been rapidly increasing until it measured 31 inches in circumference at the umbilicus. As no action of the bowels could be obtained, an iliac colotomy was performed. After the operation the boy improved in general health, and his abdomen gradually became reduced to almost normal dimensions.

## Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, Nov. 24th, 1901.

### THE SO CALLED BANTI'S DISEASE.

At the Medical Society Hr. Senator gave an address on this disease. Prof. Banti, of Florence, in 1894 and subsequent years, drew attention to a disease characterised by swelling of the spleen, anæmia, and associated with these, cirrhosis of the liver and ascites. He called the disease] *anæmia splenica*, with cirrhosis of the liver. The disease, though it had been scarcely mentioned in German literature, was not a new one, but to Banti belonged the credit of showing the connection between the individual symptoms. The affection had three stages: 1st. The anæmic, in which anæmia and enlargement of the spleen alone were present. The duration of this stage was from three to five years, and in exceptional cases, ten to eleven years. Then followed a second or transitional stage, in which the urine was scanty, containing abundance of urobilin and bile material, only of a few days duration; and, lastly, the third stage, of ascites, that runs a slow and painless, but steadily progressive course; the blood showed lessened numbers of red blood corpuscles, decrease of hæmoglobin, in some cases decrease of leucocytes; the duration of this stage was six to twelve years. In the first stage the case was nothing more than primary idiopathic enlargement of the spleen, later on associated with leucæmia. Externally it was similar to Cohnheim's disease, but in reality there was a difference. It was best described by Griesinger as *anæmia splenica*. The disease had long been known under this name. The later stage had been described as cirrhosis of the liver with ascites, but with some peculiarities, the cases not falling in with any of the known types. They showed certain peculiarities (cirrhosis of the liver with pernicious anæmia with splenic or hypersplenomegaly, or with marked hæmorrhagic diathesis).

Banti looked upon the disease as a direct result of the splenic affection, and not in the usual inverse sense of the splenic enlargement being due to the cirrhosis of the liver. Banti found the veins of the spleen and interior of the portal vein covered with atheromatous patches. The speaker also assumed that the spleen was the seat of the primary disease; but then came the question how the cause of the disease got into the spleen. Probably the point of entrance of the poison was in the intestines, which either infected the blood in the spleen directly or set up an autoxidation that caused a secondary swelling

thereof; the spleen could react to all dyscrasic conditions, both the acute and the chronic. Harmful material was therefore formed that irritated the spleen, caused atheroma, and excited hepatic cirrhosis. Bacteria had not been discovered, and the speaker's own examination of the blood had revealed nothing. Moreover, as regarded the literature in general no exciting causes had been discovered. One could less agree with Banti's explanation of the ascites; it did not occur in all cases. In some cases the liver had been found free from cirrhotic changes. The clinical symptoms were also against the ascites being a consequence of the cirrhosis. The speaker had observed two cases in which the ascites disappeared of itself or after puncture, whilst the disease itself progressed, the splenic swelling making more or less marked advances. If this were the cause the ascites must also have increased. As regarded symptomatology the tendency to hæmorrhage in the third stage was specially characteristic. Epistaxis, frequent and severe hæmorrhage from the stomach, which sometimes ushered in the disease, or sometimes appeared later, and repeated themselves, or might close the scene; he had observed the last in one case. According to his own observations intestinal hæmorrhage must be a frequent symptom. In five years he had observed seven cases, six of them with gastric, or intestinal, hæmorrhages. Other hæmorrhages also were present, bleeding from the gums, hæmoptysis, purpura in one case (that of a physician), hæmorrhage into the vitreous. The transition to jaundice with urobilin was not always observed. The patients kept their anæmic appearance, and no symptom appeared that pointed to cirrhosis of the liver. The blood changes were important. He had made accurate investigations of the blood in three cases, and had collected that of seventeen other cases. The changes he most found were characteristic. Diminution of red blood corpuscles, as considerable as constant; in general there was oligocythæmia. Less important was the diminution of the hæmoglobin, which bore no relation to the diminution in the blood corpuscles. In all his cases there was striking diminution of the leucocytes, but the extent varied. Other blood changes (increase of blood plates of the eosinophile cells) were not characteristic; in the spinal cord the changes of grave anæmia were found. If these changes were confirmed by other observers they would afford valuable aid as regarded differential diagnosis. As regarded this there were the very large splenic tumours, for which no cause could be found, and the condition could not always be distinguished from pseudo-leucæmia. It was not unlikely that Banti's disease was allied to lineal pseudo-leucæmia. The plasmodia would distinguish it from malaria, and possibly malaria was connected with the ætiology in some cases. The difficulty would be great in the case of cachectic children with splenic swelling and ascites. Jacksch had improperly described such cases as leucæmia infantum. In the later ascitic stage cirrhosis of the liver alone comes into consideration, but here there could be no mistake, as the splenic enlargement was greater than in any other disease, the spleen equalling the liver in size. Bearing this in mind no one could confound the two diseases. The ætiology was unknown; malaria had, been mentioned, and so had syphilis and abuse of alcohol but there were cases in which all these could be discarded.

Prognosis was uncertain. As regarded treatment, we had, according to Banti, a remedy in splenectomy which kept the disease in check and led to recovery. This operation was not without danger, but one could not always oppose it. Maragliano had recorded nine recoveries and two deaths from hæmorrhage after iodine, iron and arsenic, and favourable climatic conditions were to be considered. In conclusion, the speaker showed a man, æt. 33, who showed symptoms of the disease, and who was first seen in 1895, when he was in the Charité with enlarged spleen. He was back again in 1896 with anæmia and a trace of ascites. At the beginning of the present year he came again with a good deal of ascites, shortness of breath, and œdema. Twenty-five litres of fluid were withdrawn, and no more had collected in seven months. There was no fever, but great anæmia; no swelling of lymph glands; the spleen filled half the abdomen. In the blood decrease of erythrocytes, considerable increase of hæmoglobin, remarkable leucopenia; of the individual leucocytes, 25 per cent. multinuclear, the rest mononuclear.

### Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, Nov. 23rd, 1901.

#### ERYTHEMA BULLOSUM ET GYRATUM.

At the "Gesellschaft" Neumann exhibited casts of a rare case of erythema bullosum et gyratum occurring on the dorsum of the foot and the palms of the hands of a patient who had been treated for some time with arsenic for chronic furunculosis. The patient was given three minims of Fowler's solution at first, which was gradually increased.

When admitted three months later under Neumann, the patient's face was swollen and puffed, the eyelids red and partially covered with a crust. On the inner surface of the legs were small groups of bullæ, extending to the anus, while the scrotum had a red weeping eczema. On the dorsum of the left foot and in the palm of the left hand were large pustules, with red circumferences. In the urine there was found a moderate quantity of arsenic.

This is a case of peculiar idiosyncrasy, as the patient during the whole of the treatment did not take more than ten, or fifteen at the outside, of the Asiatic pills commonly used in the Vienna clinics, and composed of—*acidi arsenicosi* 0.5 gramme, *piper nigr.* 5 grammes, gum arabic 1 gramme, aqua q.s., fiat. pil. 100; this is equal to 6 milligrammes of arsenious acid in each pill. Therefore the total amount of arsenic taken would not exceed 0.15 gramme or 2.215 grains, which is a very small quantity to produce such extensive morbid changes.

Lang said that he had drawn attention to this subject before, which had brought him into conflict with his colleagues. In one case some time ago, he says, hyperkeratosis cutis was produced by a very small quantity of arsenic given for psoriasis; in another the results were somewhat similar to those obtained in Neumann's case, where large patches of exfoliation in both hands and feet occurred.

Neumann replied that the doubt was justified in the case of arsenic given for psoriasis, as frequently such cases developed hyperkeratosis when no arsenic was administered.

#### LUPUS.

Lang next exhibited a patient covered with the efflorescence of lupus over which nodules of the disease were strewn. In the centre of a large area of the disease the mammillæ were affected, while the areola around was quite free. A similar condition existed on the right forearm, which Lang treated in 1895, leaving a circumference unaffected. He excised the morbid tissue and subsequently filled in the gap by Thiersch's method. This part healed up entirely, but the place whence the graft was taken has not healed, but has become the centre of a new area of the disease. These facts tend to prove that the disease is amenable to treatment although anomalous in its mode of recovery.

In all cases with halos of healthy tissue the Röntgen rays are invaluable; the ultraviolet rays of Finsen are equally successful.

He recalled that 300 patients were being treated by Finsen, at Copenhagen, for the disease, and that the Kaiser of Austria had now fitted up a place in Vienna at a cost of 10,000 kronen out of his privy purse.

#### ANCHYLOSTOMUM DUODENALE.

Hofbauer next brought forward a patient who had suffered severely from the ravages of anchylostomum duodenale. This defied the recognised treatment with thymol, which led Hofbauer, in despair, to try an extract of male fern, with surprising success. Another point of note in this case is, that although the hæmoglobin of the blood was greatly improved the eosinophile cells present in the blood still stood at 7 per cent.

Mannberg asked what quantity of extract of male fern he gave, to which Hofbauer replied that he gave twelve capsules, which would represent about a gramme of the substance, and this was followed after three hours by a large dose of senna.

Mannberg related several cases in which the resistance to all the recognised drugs—*felix mas*, thymol, and menthol—was extreme.

Hofbauer said he had used thymol to such an extent that the patient collapsed, remaining for some time in a very dangerous condition, but without any marked effect on the parasite.

Pal drew attention to a lecture by Goldmann, of Brennborg, who had a large experience in anthelmintics particularly with the anchylostoma. He was in favour of the fern extracts, but complained greatly of their evil collateral effects, such as collapse, &c.

Gruber asked what was the employment of the patient. Hofbauer replied that he was a miner in the Brennborg district.

Mannberg said he had a silver-miner suffering from the same thing in the same neighbourhood, who told him thymol was largely used among the miners as the most effectual remedy.

#### RONTGEN RAYS AND EPITHELIOMA.

Schiff presented a patient whom he had treated with the Röntgen rays for a recurring epithelioma over the zygoma. After twenty-seven sittings he was surprised to see the neoplasm disappear.

He presented a young girl, æt. 7, who had suffered for some time with an intractable rodent ulcer. He subjected her to thirty-two sittings under the Röntgen rays, with the best results.



## The Operating Theatres.

### FRENCH HOSPITAL AND DISPENSARY.

**ABDOMINAL HYSTERECTOMY.**—Mr. R. O'CALLAGHAN operated on a woman, *æt.* 30, who had been admitted, after being under his observation for a year, suffering from a large fibroid. During the last three months she suffered from irritability of the bladder and obstruction of bowel. Rapid increase in the growth of the tumour rendered an operation imperative. The patient having been anaesthetised, an incision was made from the umbilicus to an inch above the pubes; the tumour was found to fill the whole of the pelvis, and was very difficult to deliver out of the pelvis, in which it was tightly impacted. On delivery it was found that the large intestine presented on the top, and that the fibroid had burrowed into the left broad ligament. It was therefore found necessary, after tying the uterine arteries on both sides, to make an incision into the broad ligament, detach and drop the intestine from the tumour (during which process there was considerable hæmorrhage), and next enucleate the growth, which proved to be an œdematous fibroid; it was finally removed along with the uterus, tubes, and ovaries, the uterus being amputated through the cervix. There being considerable oozing from the broad ligament a gauze drain was passed through the cervix into the vagina. The peritoneum was then closed from side to side by continuous catgut suture, and the abdominal wound sewn up in two layers, the first being a continuous catgut suture for the parietal peritoneum and the second an interrupted one of silkworm gut for the remainder of the abdominal wall, each stitch of this last taking up also the stitched ridge of the parietal peritoneum. Mr. O'Callaghan said that the case was a typical one of fibroid justifying operation, which, after being under his observation for two years, during which time the patient exhibited perfect general health, and was able to follow her occupation with no discomfort; within the last three months began to develop symptoms necessitating surgical interference, and in his opinion this was the only way for the surgeon to approach the vexed question as to when such a serious mutilation as complete hysterectomy was justifiable. He pointed out that the operation was in this case rendered a little more difficult by the fibroid having become intaligamentous, and also by the fact of the intestine lying over the tumour; this, however, accounted for the symptoms of obstruction of the bowel.

Three weeks after operation the patient was convalescent.

**NEPHRORHAPHY.**—Mr. O'CALLAGHAN operated on a woman, *æt.* 30, who had been admitted with a history of hepatic colic. On examination the gall-bladder was found normal, but the right kidney was freely movable to the middle line. Nephrorrhaphy was suggested, and the attacks of pain had been so frequent and severe that she gladly availed herself of any treatment which would promise relief. The operation was performed by an incision in the lumbar region between the last rib and the pelvis. The kidney was easily found and was anchored by two stitches of silkworm gut through the capsule to the abdominal wall; a drain was inserted down to the subperitoneal fat and the wound closed. Mr. O'Callaghan said that he considered the simple

operation he had employed as being efficacious in these cases.

The woman left the hospital in three weeks completely relieved of her very painful condition.

### CANCER HOSPITAL.

**SUBPERITONEAL HYSTERECTOMY.**—Mr. BOWREMAN JESSETT operated on a single woman, *æt.* 42, who had been admitted to the hospital suffering from a tumour in the abdomen and difficulty in micturition. She first noticed the tumour about a month before admission, her attention being drawn to it by her medical man, whom she had consulted for chronic dyspepsia. She had great discomfort after eating, vomited her food, bowels very constipated, periods regular and normal. She complained of constant desire to pass water, and occasionally she was unable to relieve herself. On abdominal examination a large, prominent, cystic swelling was seen to occupy the abdomen, extending to about an inch above the umbilicus; it had all the appearances of a unilocular ovarian cyst. On examination *per vaginam* a hard mass was felt filling the pelvis; the os uteri lying directly underneath the pubes; *per rectum* this tumour was found evidently to be connected with the uterus and very fixed. On examining the orifice of the vagina the urine was seen to be trickling from the urethra, yet the patient said she had passed water freely only half an hour ago. In view of the bladder history it was deemed advisable to pass a catheter when three pints of urine were withdrawn with the effect of the cystic tumour in the abdomen disappearing, and it became easy to examine the solid pelvic growth bimanually; it was found very fixed in the pelvis, and about the size of a large cocoa nut. Operation was recommended and abdominal hysterectomy performed, the tumour and the uterus being with some difficulty extracted from the pelvis and drawn out through the abdominal wound. The broad ligaments and uterine arteries were ligatured in the usual way, and amputation performed through the cervix uteri. Mr. Jessett said that the interest of the case was that the patient had evidently suffered from this tumour for some time before seeking advice, and appeared to be quite ignorant even then of its presence; in fact, the reason for her consulting her medical attendant was with the view of getting relief from the severe indigestion from which she suffered. On examination by her medical attendant he discovered the cystic tumour in her abdomen, and advised her to consult Mr. Jessett. This tumour had all the appearances of an ovarian cyst, and might have easily been passed over as such, for the patient maintained she always passed plenty of urine, although she had never evacuated a large quantity at a time, and it was only on account of this constant desire to micturate, and that sometimes of a night she found her linen moistened, evidently from leakage of the urine, and from the history, that on some occasions when micturating the water stopped short and she was unable to pass more for some time that had induced Mr. Jessett to pass a catheter into the bladder with the result of drawing off a large quantity of urine and the disappearance of the abdominal cystic tumour. The lesson to be learnt from this case was, he thought, as he has seen in other cases, that if you have a patient suffering from a tumour occupying the pelvis, and at the same time there is a cystic tumour in the abdomen, to always pass a catheter and evacuate

the bladder; by this means the diagnosis can be confirmed, and the surgeon is able to find the extent and nature of the growth occupying the pelvis.

The patient made an uninterrupted recovery.

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## The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, NOVEMBER 27, 1901.

### THE METROPOLITAN ASYLUMS BOARD II.

THE growth in popularity of the hospitals for infectious diseases provided by the Metropolitan Asylums Board is a most encouraging sign of public interest in prevention. During the year 1900 the notifications in the Metropolis amounted to 35,247, as against 42,285 in the previous year. The decrease is satisfactory, and has taken place in spite of an increase in diphtheria. Of the 35,247 cases, 30,243 were legally admissible to the managers' hospitals. Of the 30,243 admissible cases 21,361 were actually admitted. The remainder, mostly cases of erysipelas, but also including 237 cases of puerperal fever, were not admissible. It may be remarked, by the way, that so disastrous and eminently preventible a disease as puerperal fever might well be provided for by the managers. The ratio of admissions to notifications affords a most gratifying proof of the excellence of the accommodation afforded by the hospitals. In the year 1890, the first complete year in which compulsory notification came into force, the proportion of admissions to the total number of legally admissible cases was 33.59 per cent. Since that time the percentage has steadily increased until it reached its highest point of 70.63 in the year 1900. It is obvious from these figures that a vast mass of infection is brought more or less under control. Much remains to be done in a similar direction. Some day, perhaps, the Board will be asked to deal with those most deadly infectious diseases, whooping-cough, measles, and summer diarrhoea. It might possibly be not too sanguine to hope that when that day of enlightenment dawns upon us there will be available hospital

accommodation that has been rendered vacant by the disappearance of enteric fever and some other specific infectious maladies. It is interesting to note that the Board has been loyally supported by the medical profession, notwithstanding the fact that the public hospitals have deprived the medical practitioners of a large and lucrative class of practice. There is one point, however, in this connection as to which it may be well to indulge in a little plain speaking. In the course of the year 1900 no less than 1,706 patients, or a percentage on the total admissions of 7.8, were found to have been sent to hospital on a wrong diagnosis. It is clear that if patients are sent off to hospital on the first appearance of symptoms it is often impossible to arrive at a correct diagnosis at that early stage of invasion. An atypical case of enteric fever, scarlatina, diphtheria, or measles, again, may occasionally mislead the most skilled and cautious observers. Only a year or two since a whole series of cases of typhus fever were treated in different London hospitals and remained for a long time unrecognised. Mistakes, therefore, may be regarded as unavoidable, and the hospital medical officers act as a kind of court of appeal, where there is leisure and opportunity for fuller and more exact observation. Under such circumstances it is needless to remark that without the utmost tact and consideration a great deal of injury might be inflicted upon general practitioners. In all cases we think the Board should treat the matter as purely confidential, and send a private intimation to the notifying medical man as to the differing result of their examination. There will probably be little difficulty in smoothing the way to a businesslike understanding by a Board that has always adopted a prudent and conciliatory policy in its dealings with the medical profession. Were any serious friction to arise upon the point of errors in diagnosis, medical men would probably either keep the patients under observation until the disease were fully pronounced, or they would send in an open diagnosis of “fever.” In either case the work of the Asylums Board would be hampered and lessened in efficiency. With regard to scarlet fever it is satisfactory to learn that the Board has now sufficient accommodation for all cases. Why this should not have been the case in former years is somewhat of a mystery, inasmuch as the Board has the command of unlimited resources. The lavish outlay in the case of the Brook Hospital, a satisfactory account of which cannot be said to have yet reached the public, shows that the Board has not failed in providing the requisite accommodation because of a mistaken economy. There has been apparently a great delay in carrying out Mr. Chaplain's famous Order of April 2nd, 1899, whereby the Local Government Board authorised the managers to provide accommodation for Poor-law children suffering from ringworm, ophthalmia, mental or bodily deficiency, or who were remanded from the police-courts. Ophthalmic children will not be housed before 1903; ringworm cases are to have

temporary accommodation, but no date is mentioned; convalescent homes are not yet established; some homes are in working order for defective children; but in the case of "remand" children legal difficulties have cropped up which it is hoped will be overcome by an amending Act. This record does not seem to be altogether brilliant on the part of a public body armed with full powers and unlimited resources. Extravagant sums, moreover, seem to have been voted towards the erection of the necessary buildings in connection with the special accommodation needed for these classified children. The general work of the Asylums Board commands our admiration, especially in view of the fact that as a non-elective body it is beyond the direct control of the rate-payers.

#### THE VICISSITUDES OF DRUGS.

ONE of the most interesting of books is Sir Bernard Burke's "Vicissitudes of Families," and we often thought that the vicissitudes of drugs would make an interesting narrative of the fashions in therapeutics. We have known "red gum" to be brought from the recesses of a lumber room to the front counter case, where, as the *eucalyptus rostrata* gum, it long enjoyed therapeutic notoriety. The demand for Chio turpentine when Clay, of Birmingham, believed he found in it a remedy for uterine carcinoma brought its price from a few pence a pound to as many shillings an ounce. Lactucarium has undergone similar vicissitudes of fortune and extract of hemlock, Canadian balsam, and many others might be added to the list. One of the latest to come back into therapeutic favour is sarsaparilla. For centuries it found favour with the most distinguished European physicians. Boerhaave recommended its use as a necessity, and Baron Gerard von Swieten wrote a formula for a compound decoction of the plant, and it formed the principal ingredient in the decoctum diaeteticum of the immortal Sydenham. Almost a hundred years have passed since Dr. Charles Butler produced his liquid extract of sarsaparilla, thus utilising the broken pieces that fell from the bundles of the drug whilst unpacking it. Both the medical profession and the public looked to it as a trustworthy remedy for all forms of sores, ulcers, pimples, and such like. In time it became a legacy to quacks, and among English-speaking people gradually fell out of prescriptions. On the Continent it was not wholly forgotten in medical practice, and the Spanish physician still prescribes zarzaparilla: *smilax syphilitica*, indeed, its introduction to Spain was considered at the time almost as a divine interposition. The veterans who had accompanied El Gran Capitán, Gonzalo Fernandez de Cordova, to the siege of Naples in the year 1496 had returned. To the pen of Hernando del Pulgar we are indebted for the account of that siege and the memorable epidemic of the "French disease," which made such havoc among the Spanish troops. The pious historian tells us that the discoverers of America were inoculated

with the plague disease in reprisal for the violence of their conduct. Unchecked by treatment, the disease spread through Southern Europe as a pestilence. Some time afterwards, early in the sixteenth century, Zarzaparilla was brought to Cadiz (*El Siglo Medico*). About forty years later Senhor Rodriguez de Castello Bromeo published an account of the therapeutic virtues of the plant. One of its earliest recommendations for the treatment of syphilis was from the pen of M. Ferrier, who prescribed it for the *Lues Hispanica*. Once again the drug has become a favourite remedy under the name of Zittman's decoction, which consists of a decoction of sarsaparilla, fennel, anise, liquorice root, and senna. To this is added alum, sugar, calomel, and cinnabar. The compound closely resembles a domestic remedy which at one time was much used in Ireland. Now it comes recommended by specialists as the most useful and trustworthy of our therapeutic agents for malignant syphilis. Under its influence lesions with a horrible stale, dead odour common to the fomenting secretions of moist fungating syphilides heal rapidly. Writing in 1597, Gerarde says, "We have great plenty of the roots of this Bind-weed of Peru, which we usually call zarza, or sarsaparilla, wherewith divers griefes and maladies are cured." He adds, "The roots are a remedie against long continuall pains of the joints and head, and against cold diseases. They are good for all manner of infirmities wherein there is hope of cure by sweating."

#### FOOD PRESERVATIVES.

AT Lancaster, a few days since, the county magistrates dealt with a case which, in the present uncertain state of the law, is of much importance. A Morecambe shrimp dealer was prosecuted at the instance of the County Council for selling shrimps which were preserved with borax. The solicitor for the prosecution stated that for some time shrimps had been imported into this country from the Continent. With the intention of ascertaining whether they contained any harmful substance, an inspector of police went to the defendant's premises and asked for some "Dutch shrimps." After the purchase was made, according to the evidence of the police—and before it was made, according to the defendant—the latter said, "I never sell them in this state, they have to be soaked in salt and water for some hours, and then boiled." On analysis they were found to contain ninety-five grains of borax per pound. Mr. Williams, County Analyst, gave the result of his analysis, and added that he considered the amount of preservative excessive. Dr. Sargeant, Medical Officer of Health for Lancashire, said that borax hardened the shrimps and made them indigestible. He did not consider them a wholesome article of diet. Professor Boyce, of Liverpool, concurred on the ground that borax inhibited the "rennet" action in the stomach. He was totally opposed to the addition of any chemical

substance to preserve food. Mr. Spilsbury, Analytical Chemist, of Birmingham, for the defence said that he did not deem the amount of borax added excessive, and thought that any less quantity would not be efficient. He had taken large doses of boric acid himself without experiencing any effect whatever. Mr. A. S. Barling, Surgeon to the Royal Lancaster Infirmary, said that he had given boric acid and borax to large numbers of patients. He had known sixty grains taken daily for many consecutive months, and had not seen any harm follow. Assuming that the ordinary dose of shrimps was two ounces, the amount of borax contained, *i.e.*, twelve grains, would be absolutely innocuous. In cross-examination he admitted that he was not in favour of the unrestricted use of food preservatives. He did not consider that borax had a greater hardening effect on food than salt had. The magistrates, after patiently hearing the case for four hours, inflicted the maximum penalty, £20 and costs. Several convictions have been obtained in different parts of the country for adding boric acid to milk and cream, and at Liverpool a dealer was heavily fined for selling margarine which contained fifty-one grains per pound. There have also been cases in which the court has found in favour of the defendant. Until the committee appointed by the Local Government Board reports it is likely that there will be different decisions in different courts. As regards the harmfulness or otherwise of boric compounds, the evidence given before the Committee is contradictory, but the general tendency seems to be to regard it as harmful. Probably a middle course will be steered by the Committee, and they will limit the amount of preservative, and possibly also recommend that its presence be stated on the label.

### Notes on Current Topics.

#### The Latest Cancer Cure Fad.

It has been announced in some of the public newspapers that Lady Margaret Marsham, sister of the present Earl of Romney, has been cured of cancer by the application of violet leaves. The growth, which affected the throat, is said to have disappeared entirely under the application of an infusion of the green leaves. The weak point in the story is the failure to prove that the disease was really cancer. Most medical men would at once say that to hope to cure cancer in the way indicated would be simply to beat the air. The old herbal books recommended violet leaves for cancer, and had they proved effectual it is unlikely that their virtues would be still unratiſied in the present age of active scientific curiosity. It seems to be assumed that the verdict of the medical profession will be unhesitatingly against giving the humble violet a fair trial; yet, on the other hand, it is stated, no doubt with an equal degree of truth, that its remedial action is being "carefully investigated" at various London hospitals. One can but smile at these ebullitions of credulity of which the present

silly season has been unduly and unusually prolific. It all represents "cheap copy" for the daily press, and this is a sore temptation in times of literary penury.

#### The Origin of Uric Acid.

THE association of uric acid with gout has for more than a century attracted the close attention of medical investigators. In spite of the advances of physiological chemistry, however, the origin of uric acid in the human body still remains a more or less unsolved problem. That the acid is a normal constituent of the urine and that it is present in the blood of gouty individuals are propositions upon which all are agreed, but beyond that point the subject drifts into an outer sea that is vexed with a multitude of opposing theories. It was at one time held by many observers that a definite ratio existed between the urea and the uric acid excreted in the urine, and some physicians still impress that view upon their gouty patients and point to analyses obtained from pharmaceutical chemists as a proof of the value or otherwise of the special course of treatment that is being undertaken. The fact of the matter is that every individual appears to have his own normal ratio. Experimental diets, moreover, can be made to raise or lower the amount of uric acid excreted with precision. Taylor, for instance, on a diet free from nitrogen, had a daily output of 0.273 gramme uric acid, and 7.738 grammes of urea. On a purely milk diet the amounts were 0.284 uric acid and 36.213 grammes urea, and with a diet of 500 grammes of thymus and calf pancreas, together with bread and non-proteid vegetables, the uric acid rose to 1.5 grammes per day. From the first of these experiments it seems clear that the uric acid must have had its origin in the breaking down of the nuclear or nucleinic material of the tissues. That indeed, appears to afford a rational explanation of a portion of the uric acid excreted, while the rest comes from the purin compounds contained in the food. This two-fold origin, to some extent, accounts for the recognised importance of diet in the production of gout. At any rate the results obtained clearly demonstrate the fallacy of attaching any great importance to the urea and uric acid ratio in the urine. Another experimenter has found that three cups of coffee daily, when added to a normal diet, increased the uric acid excretion from 0.364 to 0.826 gramme. Any medical man unaware of a fact of that kind might be led into all sorts of false deductions from test tube analyses.

#### A Fee or an Inquest!

IN the course of an inquest held last week on a working man, at Ancoats, who had died very suddenly, it was alleged that Dr. Moore, who was called in just before the man died, had refused to give the certificate of death unless he received a fee of one guinea. Dr. Moore was invited by the Coroner to attend the inquest for the purpose of giving an explanation, but he declined to do so unless he received

a summons to attend, which the Coroner refused to issue. The Coroner, in summing up, animadverted very strongly on Dr. Moore's conduct in certifying the death of a patient, whom he had only seen *in extremis*, to be due to hæmorrhage, whereas a post-mortem examination showed it to be due to kidney disease. The coroner intimated his intention of laying the facts before the General Medical Council, but with the full evidence before us, as reported in the *Manchester Courier*, we do not see that Dr. Moore has brought himself within the scope of the penal clauses of the Medical Act. That his conduct was deserving of censure is possible, but as he did actually see the patient before death the demand for the payment of his fee before delivering the certificate, even under the threat of causing an inquest, is probably not "infamous conduct," however otherwise reprehensible. It is, however, highly improper that a medical man should avail himself of his power to withhold a certificate of death to secure payment of his fees.

#### Journal of Obstetrics and Gynæcology of the British Empire.

It is finally announced that the first number of a new *Journal of Midwifery and Diseases of Women*, a periodical to be devoted to the consideration of the obstetrics and gynæcology of the British Empire, will make its appearance in January, with Mr. Alban Doran as editor. He will be assisted by Dr. Berry Hart, President of the Obstetrical Society of Edinburgh; Dr. F. W. Kidd, Professor of Obstetrics and Gynæcology in the Royal College of Surgeons in Ireland; and Dr. W. J. Sinclair, Professor of Obstetrics and Gynæcology, Owens College, Manchester; and collaborators distributed through the colonies and dependencies. The new journal will be in the capable hands of Messrs. Baillière, Tindall and Cox, as publishers for a limited liability company, and among the promoters we note the names of Sir John Williams, Bart., Emeritus Professor of Obstetrics, University College, London; Dr. F. H. Champneys, obstetric physician to St. Bartholomew's Hospital; Dr. G. E. Hermon, obstetric physician to the London Hospital; Dr. Peter Horrocks, obstetric physician to Guy's Hospital; Dr. R. P. Ranken Lyle, Lecturer on Obstetrics and Gynæcology, University of Durham; Dr. W. J. Sinclair, Professor of Obstetrics and Gynæcology, Owens College, Manchester; Dr. Edward Malins, Professor of Obstetrics, University of Birmingham; Dr. Murdoch Cameron, Professor of Midwifery and Diseases of Women, University of Glasgow; Dr. J. A. C. Kynoch, Professor of Midwifery and Diseases of Women, University of St. Andrews; Dr. A. R. Simpson, Professor of Midwifery and Diseases of Women, University of Edinburgh; Dr. William Stephenson, Professor of Midwifery and Diseases of Women, University of Aberdeen; and Dr. John W. Byers, Professor of Midwifery and Diseases of Women, Queen's College, Belfast. This array of names affords a guarantee that the undertaking is powerfully supported. The prospectus is to be issued shortly.

#### The Ethics of Public Vaccinators.

In order to afford the public every facility for being vaccinated or re-vaccinated, bills have been posted in various districts of the Metropolis inviting all and sundry to avail themselves of the services of Dr. X. X., the names and addresses being given in bold type as public vaccinators for the respective districts. It is pointed out that the operation will be performed gratuitously and with Government lymph, a product of which public vaccinators have at present a monopoly. The object of this publicity is no doubt very commendable, although we fail to see the necessity for urging the public in this promiscuous fashion to obtain something for nothing irrespective of their ability or willingness to pay for the same. In any case we maintain that the unblushing publicity given to an individual practitioner is not necessary to the object in view, and is in flagrant violation of the code of ethics which regulates professional conduct in general. We see no reason why public vaccinators as such should be exempted from this beneficent law, and it remains for the profession at large to take such steps as may appear desirable to put a stop to the practice.

#### Prognosis in Disease.

THE prognosis of disease is always an uncertain question, depending as it does on so many factors, many of which cannot be foreseen. This subject is dealt with by Dr. Judson Bury in the Bradshaw Lecture on the Prognosis of Nervous Diseases. On the one hand many so-called curable affections, such as acute infective diseases, may leave behind them organic changes or permanent impairment of health; on the other hand, diseases supposed to be incurable may be arrested, or even apparently cured. Even in the case of cancer instances of spontaneous cure have been reported. Of course the diagnosis is always open to criticism, but the possibility of such an occurrence must be borne in mind. With regard to the nervous system the ordinary classification into functional and nervous diseases does not agree with the divisions into curable and incurable. Functional diseases are those in which, so far, no structural change has been found, but they are being gradually reduced owing to increase of knowledge. Yet while the origin of many of them remains unsolved, they are none the less hopelessly incurable than those due to organic changes. Dr. Bury, in his lecture, insists that the time has not yet arrived for the basing of prognostic statements upon diagnosis and pathology. Prognosis depends less upon knowledge of pathology than upon due regard to the value of symptoms.

#### River Pollution.

THE pollution of rivers is a matter which concerns all classes from the point of view of public health. This is especially the case in large manufacturing towns, where all kinds of refuse are discharged into the, so-called, rivers, which are little better than open sewers. Authorities concerned with the carrying out of measures prescribed by Act of

Parliament for the prevention of pollution of rivers have been engaged for some years attempting to solve the problem. Many rivers, however, as, for instance, the Irwell at Manchester, and the Aire at Leeds, are in a far from satisfactory condition. Mr. Naylor, Chief Inspector of the Ribble District, states that progress is being made as regards purification of streams and treatment of trade refuse. Satisfactory results have also been obtained from bacterial filters. Reports from Manchester state that the polluted water, after passing through bacteria beds at the rate of 500,000 gallons an acre per day is in a fit state for the Ship Canal, the purifying effect being due to surplus oxygen. The Ribble inspector calls attention to the unsatisfactory way in which the work is carried out, due apparently to the action of the Local Government Board in refusing to sanction loans unless land is taken up for sewage purification in addition to the tanks for the bacteria beds. The Royal Commission on Sewage Purification have expressed the opinion that it is practicable to produce by artificial processes alone, without the aid of land effluents, effluents good from a chemical point of view, and capable of being discharged into a stream without causing nuisance. Anyone who has travelled on the Manchester Ship Canal must have had the nuisance of river pollution brought before his notice in a concrete form likely to linger long in the memory.

#### An Anti-Typhoid Serum.

DR. CHANTEMESSE, of Paris, claims to have succeeded in preparing an anti-typhoid serum possessed of marked anti-toxic and anti-infectious properties. In bringing forward his statistics to prove the value of his serum, Dr. Chantemesse took the precaution to insist on the fact that the mortality of typhoid fever is higher than is generally supposed. He had collected figures which showed that the mortality is 29 per cent. in adults and about 10 per cent. in children, and the municipal returns for 1899 and 1900 show a total mortality of 18.5 per cent. He has tried the treatment in a hundred cases, partly in hospital, and partly in his private practice. Only six of these proved fatal, and in two the patients were moribund when the injections were resorted to. Judging from the notes of the cases the injections are particularly efficacious when given early in the disease, that is to say before the eighth day. After that period the injection of the serum determines a fall of temperature which, however, is only ephemeral, and it becomes necessary to repeat it at intervals. He claims that under the influence of the serum the duration of the fever is markedly curtailed, the general condition of the patient is improved, the diarrhoea ceases in the course of two or three days, and the blood pressure rises. Complications were rarely met with in the cases thus treated, and the febrile reaction which follows the injections is very moderate in degree. The number of injections required is proportional to the gravity of the case, and relapses sometimes occur in patients in whom

the disease has apparently been arrested by the serum. On the whole the results appear to have been very encouraging, but observations on a much more extensive scale, in impartial hands, will be necessary before this new serum can be admitted to the freedom of the therapeutical borough.

#### Public Slaughter-Houses.

FOR many reasons the substitution of public abattoirs in the place of private slaughter-houses constitutes a most desirable reform. The unfitness of many of the premises used by butchers under present conditions is notorious, and in not a few instances may be regarded as a danger to the public health. Then, again, with a number of private slaughter-houses proper inspection either of the living animals or of the carcasses is impossible, for the owner may not only kill at any hour of the day or night, but is entitled to refuse admission to unwelcome visitors. There can be no doubt that the proper inspection of meat demands as a first step the abolition of private slaughter-houses. The latter proposal has aroused the most determined opposition on the part of the butchers, who evidently imagine that their interests will be seriously affected by any reform of the kind. In London the County Council has hitherto been unable to carry out the abattoir schemes, which were drawn up by the Public Health Committee in 1899. That fact alone is sufficient to show the power that lies in the hands of the meat trade. In the metropolis there are some 5,000 butchers, who between them own about 450 private slaughter-houses. The killing of the lower animals for food is a necessity imposed upon man by the conditions of his existence and environment. Clearly it is the duty of the administrative authorities to see that the slaughter is carried out under circumstances that inflict no undue cruelty upon the animals themselves, while the consumer is protected as far as possible from the danger to health arising from unwholesome meat.

#### A New Plea for Cremation.

THE advantages of cremation as a scientific means of disposing of the dead are manifold. At the stage of popularity to which the practice has attained there is little need to recapitulate the reasons that render quick combustion by fire safer, from a sanitary point of view than slow combustion by the lingering processes of putrefaction. A Bristol town councillor, however, has recently advanced another ground for advocating cremation, namely, that it would afford a guarantee against premature burial. Perhaps it may help to assuage his anxieties on that point by reminding him that no instance of live burial has yet been established with that completeness of proof which is demanded by scientific investigators before accepting the truth of any assertion. In other words there is no evidence of any case of premature burial, other than that afforded by hearsay or supported by statements that are obviously riddled by fallacies of one kind and another. As a local newspaper remarks, "cremation certainly gives assurance

against the horrible fate of waking up in one's coffin from a cataleptic trance or some other form of suspended animation simulating death." The writer then goes on to say that the furnace is an agency that will make the semblance of death real with merciful celerity. We would suggest that medical science can determine with precision whether a person is dead or alive. Moreover, the ordinary process of shutting anyone up in an air-tight coffin would destroy life just as surely as exposure to a furnace. Baking a man to make sure he shall not be buried alive is a somewhat rough means of solving a difficulty.

#### The Plague in India.

THE issue of the fifth and last volume of the monumental Report of the Indian Plague Commission furnishes the world with a document of intense human interest. Perhaps the greatest lesson recorded within its voluminous pages is the recognition of the fact that the success of plague measures must depend ultimately to a great extent upon the sympathy of the native population. The day of coercion at all hazards has departed, and in its stead the milder but more hopeful methods of education and persuasion have come into sway. The attempt to stamp plague out of a vast empire where bad sanitation is the rule rather than the exception, and where the customs and habits of the population are favourable to the spread of infection, presents a task of a Herculean nature. The cardinal conclusion of the report appears to be that the observance of sanitary rules constitutes the first and most important line of defence against plague. Unfortunately the results of inoculation against the malady have not hitherto been altogether satisfactory, but the practice has the support of the authorities, and in the process of time will probably be brought nearer perfection. The statistics of mortality during recent plague years are simply appalling. Up to September, 1899, the total mortality from this cause was estimated at 430,000 deaths, figures that have during the past two years been advanced to something like three-quarters of a million. The sanitary subjugation of our Indian Empire at this rate seems likely to be as costly and formidable a task as its original political conquest.

#### The Phantom Concentration Camp Blue Book.

BEFORE our issue of last week we applied to the War Office for a copy of the Blue Book containing the Official Report upon the state of the concentration camps in South Africa, and were told that no such volume had been issued. As most of the leading London newspapers of November 16th contained articles dealing with the alleged book, the denial seemed not a little strange. On the 23rd the two other leading medical journals appeared. One of them, the *Lancet*, appears to have secured a copy of the book. The other, the *British Medical Journal*, like ourselves, failed to obtain a copy either at the War or the Colonial Office. If we are to infer that

advance reports were issued to a certain number of newspapers and journals, all that can be said is that such a preference is absolutely foreign to the national traditions and character. In any case, considering the nature of the Report the earliest information should be supplied to the medical journals. Hitherto the present Government certainly cannot complain of the conduct of medical editors, who have preserved an attitude of strict moderation concerning professional matters where they might easily have ridden the whirlwind. The unwisdom of any attempt on the part of the Government, therefore, to take steps that suggest in the remotest degree the hoodwinking or the ignoring of medical opinion is sufficiently obvious. With the political aspects of the war as a medical journal we have nothing to do. The state of the Army Medical Service and the mortality of the concentration camps, on the other hand, are things that come pre-eminently within our domain, and whether favoured by the Government or not with their Official Reports, we shall feel it our duty to discuss those particular matters without fear or favour.

#### The Notification of Consumption.

THE Stoke Newington Borough Council have adopted the voluntary notification of phthisis. On the receipt of the intimation, the Medical Officer of Health will inquire into the circumstances and surroundings of the patient, with a view to the detection and removal of conditions likely to promote the disease. He will leave instructions, verbal and printed, and will offer to perform all necessary disinfection of rooms, bedding, &c. Arrangements will be made for the gratuitous bacteriological examination of sputum in doubtful cases, and the usual notification fees will be paid to practitioners for information of the existence of any case of phthisis on the same premises not previously notified.

#### Annual Meeting of Fellows and Members of the Royal College of Surgeons of England.

THE Annual Meeting of the Fellows and Members of the Royal College of Surgeons was held on the 21st inst., in the theatre of the College, when the usual series of sterile resolutions were passed, calling upon the Council to do this, that, or the other, in spite of the knowledge that such resolutions will be treated as mere *obiter dicta* by those in authority. One cannot but admire the patience and perseverance of the gentlemen who, year after year, go through the empty formality of proposing, seconding, or voting for stillborn resolutions. As a matter of history, we note that a motion brought forward by Dr. Thomas Morton in favour of a certain proportion of Council members being elected by the members, was passed by a very large majority. This is distinctly a reasonable proposal, and the College would unquestionably gain in status by broadening its constituency. Mr. George Brown, who is very much *en evidence* just now by reason of the approaching election, proposed a motion censuring the College for its behaviour towards the General Medical Council in respect of the instruction of

students in science. Mr. Bryant objected to the topic being introduced, on the ground that it was still, so to speak, *sub judice*; but it was carried nevertheless. At the instance of Dr. Danford Thomas the President promised that the proposed Medical Acts Amendment Bill, promoted by the British Medical Association, should receive the closest attention. Lastly, a resolution which laid down the principle that the representative of the College on the General Medical Council should be elected by Fellows and members of over ten years' standing was passed—and there the matter ends. We are in sympathy with all the resolutions, but unless means can be found to gain the ear of the Council—or of Parliament—we are fain to ask *Cui bono*?

#### The Improvement of the Human Race.

ANY suggestion for the improvement of the race of mankind must of necessity command attention. It was the subject of the Huxley Memorial Lecture, recently delivered by Mr. Francis Galton with the title "The Possible Improvement of the Human Breed under Existing Conditions of Law and Sentiment." Mr. Galton suggests that wealthy persons might devote their surplus cash to the befriending of young healthy couples, and so produce a more healthy race. That such a condition of things is ever likely to occur is remote in the last degree, for it would reduce marriage to the level of a breeding pen. Moreover, it by no means necessarily follows that the race would be improved, except perhaps physically; for we know perfectly well that many great minds, which have benefited the world for all time, have been tenants for life of more or less debile or deformed bodies, a circumstance which is not apparently incompatible with great intellectual activity. It is true that Mr. Galton's idea, if carried out, might possibly lead to the development of a race of athletes; but that it would raise the standard of intellect, or improve the human race on the whole, there is not enough evidence to show.

#### Pseudotabes.

As the physician grows in years he comes more and more to recognise the difficulties that beset accurate diagnosis. This is particularly the case in nervous diseases. Erb, writing in 1868, warned his readers of the accidental complications with central nervous disease that may mask peripheral paralysis. These difficulties of diagnosis were recognised since the days of Hippocrates, and described by such writers as Galen and Bonetus. And Todd, of encyclopædic fame, writing in 1847, urged the adoption of the term inco-ordination in place of paralysis in tabetic troubles. Romberg, in his classical description of spinal diseases, and afterwards Duchenne and Trousseau recognised the difficulty of accurate diagnosis in spinal diseases. We are led to these considerations from an exhaustive clinical history of a case of pseudotabes, published by M. Millo. The case had been diagnosed as one of tabes, and treated as such during the patient's lifetime, the true condition being made plain by the post-mortem

examination alone. The patient, a man of seventy-five years of age, had lumbago pains, which were ascribed to cold and overwork. He was unsteady on his limbs, ataxic in his gait; the knee reflex was exaggerated; there was no ankle clonus, he had the Argyll-Robertson pupil, muscular atrophy of his legs, diminished tactile and other sensibility, with difficulty in micturition. Withal the spinal cord throughout its whole length was found to be perfectly healthy. The lesions found were degeneration of the peripheral nerve endings and muscular atrophy. We may just add that the symptoms came on gradually and became more and more ataxic during the twelve years the patient suffered. This is just one of those exceptional cases that come to the doctor's study to remind him of the folly of dogmatic writing on the subject of diagnosis. In one of our most valuable text-books we find:—"In neuritis causing pseudotabes we have a history of rapid onset of the symptoms, paralysis and wasting of the muscles, and an absence of vesical symptoms and the Argyll-Robertson pupil." No fault can be found with a statement that holds good in fully 99 per cent. of cases. Nevertheless, the exceptional case presents itself to remind us of the necessity of keeping in mind the great axiom of the immortal Sydenham; "Treat the individual." It is the recognition of this fact, that we prescribe for the patient, that differentiates the physician from the quack.

#### Erroneous Death Certificate.

AN instance of what looks like careless certification of death is reported from the Northern Hospital at Liverpool where the medical officer issued a death certificate on the strength of a simple message that an out-patient child had died. It subsequently transpired that a mistake had been made in the name, the child in question being still living. The matter is being investigated, but on the face of it the fault, if any, lies with the present system of death certification rather than with the medical officer, who cannot be expected to personally inform himself of the *bona fides* of death declarations in respect of out-patients.

#### Icterus Neonatorum.

THE pathology of icterus neonatorum is still in many cases very obscure, and it is probable that here, as elsewhere, the jaundice must be looked on as merely a symptom due to many different causes. In a paper entitled "Some Interesting Experiences in Obstetrics," in the August issue of the *American Practitioner and News*, Dr. W. E. Sleet records a very remarkable case illustrating this. In December, 1894, a patient, aged 18 years, was delivered of her first child, who is now a strong and well-developed boy. Since that time she has had four pregnancies as follows:—December, 1897; October, 1898; January, 1900; and March, 1901. In each of these cases the child at birth appeared healthy and perfectly well developed, but within a few days died from icterus neonatorum. In the case of the fourth



child, a son weighing about eight pounds, death resulted from icterus three days after birth, and the post-mortem examination showed that the following conditions were present:—The hepatic and cystic ducts appeared normal, while the gall-bladder was rudimentary and contained about half a drachm of serous fluid. The common bile duct was absent and represented merely by a fibrous cord, the liver was of normal size, and there was no cirrhosis. There is no record of the meconium passed, or of the state of the intestines, but the child showed no evidence of icterus till some twenty-four hours after birth. There appears to have been no post-mortem made in any of the three cases.

#### The General Medical Council Election.

IN consequence of Dr. Glover's withdrawal there are practically only three candidates before the profession as candidates for the two vacancies on the General Medical Council as "direct representatives" for England and Wales—viz., Mr. George Brown, the retiring member, Mr. George Jackson, and Dr. Woodcock. A study of the addresses issued by the various candidates does not materially assist one in apportioning their respective merits and the differences, such as they are, bear rather on the means by which the reforms, common to them all, are to be obtained. Mr. Brown is radical or nothing, and Mr. Jackson appears to have "toed the line." Dr. Woodcock seems disposed to distinguish the practicable from the merely desirable, and this is a commendable quality, since practitioners desirous of supporting reforms are confronted with the possibly unwelcome fact that the Council does not fashion its destinies, these being controlled by statute. We cannot help thinking that mere clamour against the registration of midwives is bad policy. What should be aimed at is to obtain efficient control of the medical education of these women before they are admitted to registration. The vexed question of Medical Aid Associations is naturally one which appeals very strongly to practitioners, but the powers of the Council in the direction of preventing unfair competition are strictly limited, and such as they are require the most thoughtful administration. A Medical Act Amendment Bill is, no doubt, extremely desirable, but it will probably take more pressure than the direct representatives can bring to bear to induce the General Medical Council to quit its supine attitude and to take up the cudgels for the purpose of obtaining additional powers from the Legislature. On the whole it would seem that the forthcoming election will be decided mainly on personal lines, though geographical considerations may carry weight with some. Into the personal qualifications of the candidates we do not propose to enter. Electors can study the past record of Mr. George Brown, whose indefatigable activity has not perhaps been attended by results commensurate with his efforts; indeed, he has but too often been the *vox clamans in desertis*. The others, Mr. Jackson and

Dr. Woodcock, must be judged by their addresses, respecting which our readers can form their own opinion.

#### Mentone Hotel Keepers and Consumptives.

THE action of the syndicate of hotel keepers in "warning off" consumptives has led to a lively campaign in the Press, on the whole in a tone adverse to the proposed boycott. There is reason to believe that many of the hotel proprietors are "sorry they spoke," at any rate, in the way they did. No one would contest the desirability of, as far as possible, excluding persons in an advanced stage of consumption from hotels mainly inhabited by travellers in good health—indeed, it is an imperative duty. When, however, a resolution is agreed to which, if construed literally and applied harshly, would close Mentone to ordinary invalids and those with "consumptive" tendencies, it is another matter. It must be borne in mind that a very large proportion of those who fly south to avoid the northern winter do so for reasons of health, and if refused a welcome at Mentone, they will assuredly transfer their patronage elsewhere.

IN an action brought by a medical man to recover fees for professional services the Judge of the Wood Green County Court, in giving judgment for the plaintiff, expressed the hope that medical men would in future prosecute their claims, their not doing so being productive of harm in that their abstention engendered the belief in the minds of a section of the public that payment of bills was an unnecessary formality. One could only wish that County Court judges generally displayed more sympathy with the hard-worked and unpaid practitioner.

A VERDICT impugning the carefulness of the Health Department of St. Louis, U.S.A., has been returned by the Coroner's jury in respect of the anti-diphtheritic serum, the injection of which was followed by several fatal cases of tetanus. This is an error which is likely to cost the authorities dear.

AN epidemic of whooping-cough is causing great ravages among the young population of British New Guiana. The high rate of mortality of the disease is attributed to the superstitious practices of the natives who consult the local sorcerer in preference to the doctor.

#### PERSONAL.

DR. JOHN HOENE, of Scarborough, has been placed on the Commission of the Peace for the North Riding of Yorkshire.

THE appointment of Dr. Geo. Thornton as Medical Superintendent of the Civil Hospital, Pretoria, has been confirmed by his Excellency, Lord Milner.

WE hear that there are already a good many applicants for the post of Medical Officer to the School Board for London. The salary is £800, rising to £1,000.

DR. MAURICE-GEORGES DEBOVE, Professor and Agrégé

at the Faculty of Medicine of Paris, has been elected Dean of the Faculty, vice Dr. Brouardel, who resigned after fifteen years' tenure of office.

MRS. CALVERLEY BEWICKE gave a dramatic recital in the Jerusalem Chamber of Westminster Abbey last week in aid of the funds of the Westminster Hospital. A substantial sum was realised for this very deserving institution.

DR. GOODHART is to deliver the Purvis Oration before the West Kent Medico-Chirurgical Society, on Friday, December 6th, at the Royal Kent Dispensary, Greenwich Road, taking for his subject, "General Practice and Original Research."

MR. E. F. DRAKE-BROCKMAN, F.R.C.S., of London, has presented to the Museum of the Royal College of Surgeons a complete set of surgical instruments used by the Indian "native doctors" in ophthalmic operations. These were collected by Mr. Drake-Brockman's son Major Herbert Drake-Brockman, of the Indian Medical Service.

MR. T. R. JESSOP, F.R.C.S., consulting surgeon to the Leeds Infirmary, will deliver the Bradshaw Lecture at the Royal College of Surgeons, London, on the 11th prox., the subject being "Personal experiences in the surgical treatment of certain diseases." The invitation to be present extends to all members of the profession, and to medical students.

## Scotland.

[FROM OUR OWN CORRESPONDENTS.]

### PREVENTION OF TUBERCULOSIS.

AN influential public meeting, presided over by the Duke of Argyll, was held in Glasgow on the 19th inst. Most of the municipal leaders, as well as the most prominent medical men in Glasgow, were present. Sir James Crichton Browne was the principal speaker, and explained the objects of the National Association for the Prevention of Consumption, under whose auspices the meeting took place. Scotland has not kept pace with England in the campaign against the disease, its mortality being 17 per 1,000, as against 14 per 1,000 in the sister country. The death-rate in Glasgow—20 per 1,000—is even higher, though this, of course, contrasts favourably with the death-rate in many Continental cities. The Lord Provost, while declining to commit himself as to the duty of municipalities in providing sanatoria for consumptives, said that the Corporation was resolved to do all in its power in the line of preventing tuberculosis, whether or not it took further steps towards curing it. It is understood that some of the already existing medical charities will benefit largely from the surplus realised by the Exhibition just closed. Would it not still further crown the unprecedented success of that undertaking if some part of the funds in the hands of the promoters were devoted to the removal of this scourge of tuberculosis? At a meeting of the Town Council subsequent to that at which the Lord Provost spoke the sum of £500 was voted to the National Association for the Prevention of Tuberculosis.

### GLASGOW FREE FROM PLAGUE.

The three patients suffering from bubonic plague have now been discharged from hospital, and as no further cases have occurred, the city, after having been infected for about four weeks, is again free from the disease. Ten days, counting from midnight of the 18th, must, however, elapse before Glasgow is officially recognised by foreign authorities to be clear of plague. The Central Hotel, to which the outbreak was limited, was re-

opened on the 20th inst. The successful stamping out of the plague at so short a time is an interesting object-lesson, in view of the paramount importance which the recently-issued Plague Commission Report ascribes to the early recognition of the first cases which occur in a district.

### RECTORIAL CELEBRATIONS IN EDINBURGH.

These took place on a larger scale than usual last week. On Wednesday night there was the usual torch-light procession. On Thursday afternoon the Lord Rector, the Marquis of Dufferin and Ava, delivered his address, which was followed by an "At Home" in the University Union, and by a "Students' Night" in one of the theatres, all the seats in which had been retained by the Students' Representative Council for the occasion. On Friday the Lord Rector was entertained to dinner by the University Conservative Association. The proceedings passed off harmoniously, Liberals and Conservatives sinking their differences for the nonce, although a good deal of adverse comment was excited by the rowdiness and interruption to which Lord Dufferin was exposed during the delivery of his address. His lordship came to Edinburgh at considerable personal inconvenience and risk to his health. His speech had all the grace and charm which were to be expected from his career as a diplomatist, and the fact that he was unable to make himself audible to the majority of his listeners was surely a reason for sympathy rather than an occasion for jocular interruption. But, after all, the rather severe strictures which have been passed on the behaviour of the students are scarcely warranted. A comparative study of Rectorial functions discloses the fact that while the Lord Rector is always expected to deliver an address, he is never by any chance listened to quietly. Individually, the student is a gentleman; collectively, he has all the attributes of the "roaring human boy," accompanied by a liability to what may be described as contagious emotional discharges. At all events, it is satisfactory to learn from Lord Dufferin that he was gratified by the kindness and enthusiasm of his reception.

### DRINKING CLUBS IN EDINBURGH.

The police have lately been singularly successful in their efforts to suppress what was rapidly becoming a social pest. It has been a matter of notoriety for some years that, while public-houses are closed on Sunday, there was never the slightest difficulty in obtaining as much whisky (and, as subsequent events have shown, worse whisky) on the first day of the week as on any other. Under the guise of "social clubs" shebeening has been carried on with scarcely an attempt at concealment. It was proved that in these so-called "clubs" no formality in the way of election further than the inscription of the name in a roll book was necessary, no ballot-box existed, while the committee were usually self-elected. No means of recreation was provided, the club premises consisting generally of one or two almost unfurnished rooms, which were given up to the sale of drink. A great many of these clubs have been raided during the past months, and convictions have been secured without difficulty; as a result most of those in existence have closed their doors—temporarily at least.

## Obituary.

### SURGEON-GENERAL W. G. N. MANLEY, V.C.

THE death of Surgeon-General Wm. G. N. Manley took place at his residence at Cheltenham on the 16th inst. The deceased had a very active career, having served with the Royal Artillery in the Crimea from June 11th, 1855, including the siege and fall of Sebastopol (medal with clasp and Turkish medal). He was also with the Royal Artillery in the New Zealand War of 1864-66, volunteered and accompanied the storming party at the assault of the Gate Pah, near Tauranga, and was awarded the Victoria Cross for his conduct during the assault on the Rebel Pah, near Tauranga, New Zealand, on April 20th, 1864, in most nobly risking his own life,

according to the testimony of Commodore Sir William Wiseman, in his endeavour to save that of the late Commander Hay, of the Royal Navy, and others. Having volunteered to accompany the storming party into the Pah, he attended on that officer when he was carried away mortally wounded, and then volunteered to return, in order to see if he could find any more wounded. It is stated that he was one of the last officers to leave the Pah. He was thanked in general orders, and promoted Staff Surgeon for "distinguished and meritorious services rendered to the sick and wounded during the operations in New Zealand" (medal). In 1870-71, Surgeon General Manley served with the British ambulance in the Franco-German War, and was in charge of "B" Division of the Ambulance, and attached to the 22nd Division of the Prussian Army. He was thanked by General von Wittich, commanding the division, and received the Steel War Medal; also, at the request of the then Crown Prince, was granted by the German Emperor the Second Class of the Iron Cross "on account of his devoted and excellent conduct in seeking out and caring for the wounded of the 22nd Prussian Division in the actions of Cheateuneuf and Bretoncelles on the 18th and 21st November, and the battles of Orleans and Cravant on the 2nd to the 10th December, 1870." He also received the Bavarian Order of Merit. Surgeon-General Manley was also present at the Siege of Paris, and, on the declaration of the armistice, proceeded into the city with supplies for the hospitals. In 1878-9 he served in the Afghan War (medal), and in 1882 in the Egyptian War as Principal Medical Officer of the Second Division, being present at the Battle of Tel-el-Kebir (mentioned in despatches), promoted Surgeon-General (medal with clasp Third Class of the Osmanieh, and Khedive's Star).

HENRY SUTHERLAND, M.D., M.R.C.P., &c.

We regret to have to announce the death of Dr. Henry Sutherland, whose death occurred in London early last week. He was the second of six sons of the late Dr. Alexander John Sutherland, and grandson of the late Dr. Alexander Robert Sutherland, both of whom, for many years, held the office of physician to St. Luke's Hospital for the Insane. Dr. Henry Sutherland was born in 1842, and became a member of Christ Church, Oxford. He proceeded to the degree of B.A. in 1864, and M.A. and M.B. in 1869. He studied medicine also at Addenbrooke's Hospital, Cambridge, and at St. George's Hospital, London, and began the study of mental diseases first at Bethlehem Hospital, and subsequently as resident medical officer at the West Riding County Lunatic Asylum. Dr. Sutherland came to London in 1870, became a member of the Royal College of Physicians, and in 1872 took his M.D. degrees. The same year he was elected lecturer on psychological medicine to the Westminster Hospital Medical School, a post he continued to hold until 1887. He was physician to the St. George's, Hanover Square, Dispensary, a vice-president of the West London Medical Chirurgical Society, and a Fellow of the Medical, Obstetrical, and the Royal Medico-Chirurgical Societies, as well as of the Medico-Psychological Association and of the Pathological and Clinical Societies. He was the author of "A Directory of Justices in Lunacy," of two articles in "Juke's Dictionary of Psychological Medicine," and of numerous papers on subjects connected with insanity contributed to the medical journals.

### Correspondence.

[We do not hold ourselves responsible for the opinions of our correspondents.]

#### UNTRUSTWORTHY SERUM.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I cannot help wondering what useful purpose the writer of the letter signed "M.D." hoped to achieve. He does not frankly challenge the efficacy of anti-diphtheric serum injections, but he indulges in a sneer all round. Certainly it must be a matter of regret to us all that, from carelessness or want of skill, injections of

this lymph have on two occasions, in two countries far apart, given rise to fatal tetanus. That, however, reflects on the manufactures of the serum, and not at all on the method; indeed the fact that, in spite of the wide and instant publicity given to such accidents, only two instances have been recorded, tends to prove that the accident is an avoidable one, and in future no doubt no serum will be issued until it has been appropriately tested by direct experiment.

"M.D." is evidently a practitioner with a limited experience of the use of the serum, either practical or theoretical; witness his ignorance of the names of those concerned in the discovery of the bacillus of diphtheria, and I would suggest to him that in future communications on the subject he should deal with it in a scientific and logical manner, and not merely sneer at what he apparently does not understand. When he commits himself to positive statements it will be time enough to take up the cudgels in defence of a method of treatment which has imposed itself on all civilised communities.

I am, Sir, yours truly,

A LONDON M.D.

#### DAMAGES FOR PREMATURE BURIAL.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—With reference to the startling case of premature interment reported in the MEDICAL PRESS AND CIRCULAR of November 20th, kindly permit me to say that, in the report I read of the terrible occurrence, it was stated that a post-mortem examination had been made of the body of the lady, and she was found not to have suffered from yellow fever, and that death resulted from asphyxia in the coffin. Although "the contraction of the muscles in *rigor mortis*" might account for the expulsion of the child in some instances, this was a clear case of burial alive. In his monograph on "Premature Burial," Dr. Franz Hartmann cites a somewhat similar horrible incident, taken from the Vienna papers.

"In the year 1893, there died in a small town in Styria (Austria) a young pregnant woman, and after waiting the customary three days she was buried in the churchyard. Some days after the burial a rumour was circulated that she had been poisoned by her husband, and the grave was opened by order of the authorities. It was then found that she had but very recently died, and the appearance of her body indicated that she had undergone a terrible struggle. Moreover, she had given birth to a child in her coffin. The physician who had signed her certificate of death was sentenced to a few weeks of imprisonment as a punishment for his carelessness."

Hasty burial is not confined to France, but is frequently practised in this country, and THE MEDICAL PRESS AND CIRCULAR does great service by calling attention to the perilous procedure. It is high time that legislative reforms were initiated to remove all danger of the possibility of burial alive happening to anyone in the United Kingdom. At present no one is secure from the fearful doom, unless he be killed outright by serious accident.

I am, Sir, yours truly,

JAS. R. WILLIAMSON.

1, Egbert Street, Regent's Park, N.W.,  
November 22nd, 1901.

#### COVERING A BONE-SETTER?

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Not long ago the following extraordinary case came under my notice:—

A young man had had a quarrel with another man who struck him on the head with the handle of a hay rake, inflicting severe injuries, viz., an extensive depressed fracture of the parietal bone on the right side, and rendering him unconscious for a considerable period.

He was carried home, and one of the numerous "bone-setters" (I believe this man was called a "skull doctor") who infest these parts was summoned to attend him, and the following line of treatment was adopted:

First a quantity of hair-oil, a bottle of which the

patient had in his house, was poured into the wound. When this was exhausted, melted butter, which, I understand is a favourite remedy with these "skull doctors" in head injuries, was used instead.

Three pounds of butter were used during the five weeks the wretched man was under the bone-setter's tender mercies. Also the patient was not given much chance of over-eating himself, as the following very restrictive diet will show:—Half a slice of dry toast and three pints of milk and water in the twenty-four hours! To quote his own words, "I was ravenously hungry all the time, and longed for food," but the dietetic programme was rigorously enforced.

When I saw him he was dying from want of nourishment and the filthy poisoned wound in his head. The suppuration had burrowed extensively under the scalp, forming a puffy tumour over and around the fractured portion of skull, and out of two openings in the scalp the foul and fœtid pus on pressure poured in enormous quantities. It is an appalling state of things that such cases can occur daily as they do without any effort being made to put a stop to them.

But, Sir, the strangest fact of all in this case was that, according to the patient, a medical man, practising in the same district and holding a public medical appointment, was attending in conjunction with the bone-setter, and was present while the hair-oil and melted butter was being used, and, I presume, approved of all the treatment.

It is therefore scarcely to be wondered at if medical men so far forget themselves for the sake of a few pounds, or perhaps a few shillings, and by this countenance and encourage these bone-setters, that the country swarms with such parasites who reap a rich harvest from their ignorant dupes. I wish to ask you, Sir, if this medical man has by his action in this case laid himself open to a charge of infamous conduct in a professional sense? Before closing this letter I wish to mention that the foregoing facts were obtained from the patient himself and from enquiries made by the police who are looking for the man who inflicted the wound. Hoping you will in the interests of the public and the medical profession publish this,

I am, dear Sir, yours faithfully,  
GEORGE H. RUSSELL.

Cashel, co. Tipperary, November 18th, 1901.

[It is difficult to believe that the information our correspondent has received can be correct. If true, however, it is undoubtedly a case to be brought to the notice of the General Medical Council.—Ed.]

#### "PLAGUE."

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—No one would blame a general injunction to authorities to look well to the "sanitary" condition of their districts at any time, but it seems reasonable to ask whether the recommendation contained in the article in your issue of November 13th is a complete statement of the precautionary measures necessary in the case of plague, or an indication of the actual direction they should take.

At the present moment the accumulated knowledge as to the behaviour of plague is well represented in Koch's explicit statement at the Tuberculosis Congress which was reported in your columns:—

"Now we know," said Koch, "that every disease must be treated according to its own special individuality, and that the measures to be taken against it must be most accurately adapted to its special nature—to its etiology. The pestilence which is at this moment in the foreground of interest, the bubonic plague, may be instructive to us in several respects.

"It has been discovered that only those plague patients that suffer from plague pneumonia—a condition that is fortunately infrequent—are centres of infection, and that the real transmitters of the plague are rats. There is no longer any doubt that, in by far the majority of cases in which the plague has been transmitted by ocean traffic, the transmission took place by means of plague among the ship rats. It has also been

found that wherever the rats were intentionally or unintentionally exterminated the plague rapidly disappeared, whereas at other places, where too little attention had been paid to the rat plague, the pestilence continued. This connection between the human plague and the rat plague was totally unknown before, so that no blame attaches to those who devised the measures now in force against the plague if the said measures had proved unavailing. It is high time, however, that this enlarged knowledge of the etiology of plague be utilised in international as well as in other traffic."

Koch is by no means alone in emphasising the urgent importance of rat infection: Manson has eloquently insisted upon it; the experience of Dr. Ashburton Thompson at Sydney in 1900, and more recent experience in Calcutta confirms it, the Formosa outbreak of 1896 was even known as "rat-sickness," observer after observer notes it: the cultured lay intelligence, as represented by the *Quarterly Review*, is so impressed by the evidence adduced as to be ready to admit that the belief which through recent experience has been slowly crystallising in many minds that plague is primarily a rat disease and only secondarily a human disease, may be the key to the position.

With this knowledge already widely accumulated, with the fact before us that at Glasgow bubonic plague amongst people was readily suppressed even with the advantage of some start; that at Hull "pneumonic" plague amongst people was also, though with some difficulty, ultimately suppressed; and with the evidence that in outbreak after outbreak the implication of rats is, indeed, the uncontrollable factor, it is necessary to deal with this disease, following Koch's advice, according to its special etiology, otherwise we are but beating the air. Evidence of the association of the spread of disease with "insanitary" conditions may readily be fallacious; the mere fact that small pox spreads more readily in a poor locality than in a rich locality does not prove that "insanitary" surroundings, or such conditions as can be remedied by soap and water, have anything to do with this as a cause, beyond the "insanitary" facts in regard to small pox that the poor are habitually more careless about vaccination, are under less vigilant medical supervision, and mix more freely during illness than the rich.

So with plague; if this is indeed a disease in which animal infection is a prime factor, as accumulating evidence seems to insist, "scientific sanitation" must look further than to mere dealing with drains and dirt; and, while these need never be neglected, advice with regard to plague prevention which looks no further is not only incomplete, it is misleading.

I am, Sir, yours truly,

D. S. DAVIES, M.D.,  
Medical Officer of Health, City and Port of Bristol.  
Public Health Department, 40, Prince Street, Bristol.  
23rd Nov., 1901.

#### THE MEDICAL GUILD CIRCULAR.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I beg to enclose copy of protest which is being signed by members of the Guild Council with respect to the irregular action of the chairman of the meeting in putting the resolution of which no notice had been given on the agenda enclosed.

I have clear evidence that the meeting was "packed" by the partisans of Dr. Woodcock, showing that it was intended to obtain a "snatch vote," as I told the meeting, and requested the secretary to record that expression in the minutes. I am, Sir, yours truly,

G. H. BROADBENT.  
8, Ardwick Green, Manchester, Nov. 23rd, 1901.

[Copy of protest received, "marked several prominent members have already signed."—Ed.]

#### A Medical Fraud.

A MAN called Charles Perry, age 45, described as an American physician, was sentenced to a term of imprisonment last week for a series of frauds on medical men and chemists in London.

## Literature.

### BALL ON DISEASES OF THE NOSE AND PHARYNX. (a)

THIS admirable handbook has deservedly reached a fourth edition. The knowledge of diseases of the nose, especially those of the accessory cavities, and those of the pharynx due to mixed infection, is so much wrapped up in obscurity, and the treatment is so slow and difficult that an honest attempt to put the whole subject before a practitioner or senior student in a practical and intelligible way is no mean task. The fact that inflammation of the antrum of Highmore may give rise to severe supra-orbital neuralgia is not as consoling to the diagnostician as it is to the dissector of the trigeminus. In the diagnosis of diseases of the accessory sinuses, it is evident that disease of the antrum must be excluded first. The author lays stress on the subjective sensation of fœtor, some stoppage of the nose, intermittent discharge of pus and on transillumination. Puncture of the antrum in the manner advocated by Lichtwitz is preferred. The trochar, the point of which is guarded by the cannula, is introduced in an upward and outward direction beneath the inferior turbinate body as far as the middle of the meatus. The point having reached the part to be perforated in the upper part of the outer wall of the meatus, about an inch and a half distant from the nasal spine, the cannula is drawn clear of the point, and the trochar is pushed through the wall. The point of puncture selected should always be close to the roof of the meatus. This treatment often avoids the sacrifice of a healthy tooth if combined with opening through the alveolar process or canine fossa. In disease of the frontal sinus there is often tenderness at the upper and inner angle of the orbit. The utility of transillumination is often much diminished by the frequency of asymmetry of the sinuses, and the not infrequent absence of one or both sinuses. In diagnosing disease of the ethmoidal cells we are told to suspect crusts, pain over lachrymal bone, and stoppage of the nose. Removal of a large portion of the middle turbinal is often required, but "it must be admitted, however, that in certain cases it will be impossible to decide if the source of the pus is in the frontal sinus or in the ethmoidal labyrinth, or, as is often the case, in both these cavities. If pus can be seen by posterior rhinoscopy at the vault of the pharynx close to the cloaca or on the posterior extremity of the middle turbinal you may suspect empyœma of the sphenoidal sinus. The exact diagnosis between this and empyœma or suppurating post-ethmoidal cells is difficult, and involves endless trouble and patience. The author shows a preference for old tried remedies, e.g., in acute tonsillitis instead of advocating these new synthetic remedies he prefers the tincture of perchloride of iron, occasionally quinine, and sometimes salol.

The treatment of ozœna by cupric electrolysis is not spoken very hopefully of. We must confess surprise that strong solutions of liq. sod. chlorinat. are not even mentioned under this heading. Under the head of lupus of the nose we find no mention of the Finsen treatment or by the X-rays, but this is hardly an omission, as the treatment by scraping followed by actual or galvano-cautery is so successful. For hay fever a pill is recommended containing quinine gr. jss, iodide of arsenic gr. 1/24, ext. of belladonna gr. 1/12 three times a day. The author shows a strong liking for iodine in most chronic affections, e.g., chronic pharyngitis he uses iodi. gr. x, pot. iodid. gr. xx, glycerine ʒj; in addition to this Schliech recommends the addition of oil of peppermint (m.ij to ʒj) for its anæsthetic effect on the mucous membrane. The type, illustrations, and general get-up of the book are far above the average.

### JELLETT ON MIDWIFERY. (b)

THIS compact volume, embodying as it does, the

(a) "A Handbook of Diseases of the Nose and Pharynx." By James E. Ball, M.D., London, Physician West London Hospital, &c. Fourth Edition. With sixty-one illustrations. London: Baillière, Tindall and Cox 1901. 7s. 6d.

(b) "A Short Practice of Midwifery." By Henry Jellett, B.A., M.D., B.Ch., B.A.O. (Dublin University), F.R.C.P.I., &c.; Ex-Assistant Master, Rotunda Hospital; University Examiner in Midwifery and Gynecology, Dublin; &c., &c. Third Edition. London: J. and A. Churchill. 1901. Price 8s. 6d.

treatment adopted in the celebrated Dublin School of Obstetrics, will be found a very satisfactory and comprehensive guide to the practice of midwifery. It is true that in sundry important details the measures advocated are at variance with those adopted elsewhere, but the author's views are securely based on experience gained at the Rotunda Hospital, and will command respect if not acceptance. For instance, he deprecates the routine employment of the douche, a practice to which many eminent obstetricians are wedded, while, on the other hand, he runs counter to a generally accepted canon of the art by advocating plugging the vagina in accidental (external) hæmorrhage. Here, however, we must defer to the authority of Dr. Smyly, who has applied this method with excellent results, and has been enabled to disabuse our minds of the apprehension, usually inculcated, that by so doing an external would be thereby converted into an internal hæmorrhage. He prefers morphine to chloroform or chloral in the treatment of eclampsia, but the discouragement which his advice on the treatment of this condition in general tends to create is counterbalanced by the knowledge that much may be done by intelligently applied prophylactic measures to avert the distressing and dangerous manifestations of this morbid state. We must confess to some surprise at seeing *deciduoma malignum* dealt with as a morbid entity. We were under the impression that its sarcomatous nature had been conclusively demonstrated. The author's classification of varieties of extra-uterine pregnancy is a purely theoretical conception, and can serve no useful purpose outside the examination hall. There are chapters on infant feeding and infantile diseases, which will be useful to the practitioner, and readers of a statistical turn of mind may find food for reflection in the report of the Rotunda Hospital for the past two years. It would be useful if writers on obstetrics would say a few words as to the behaviour of the uterus immediately after labour, i.e., for the twenty-four hours following delivery. It undergoes remarkable variations in size during that period and they deserve notice, if only to avoid needless alarm. We have nothing but praise for the volume as a whole, and we can safely recommend it as a guide to practical midwifery.

### CHESTER'S MANUAL OF DETERMINATIVE BACTERIOLOGY. (a)

THIS work will be simply invaluable to the student working in the laboratory. Without these tables, which serve more for purposes of identification than for classification, the work of determining unknown bacteria without the expenditure of a great amount of work would be impracticable. The tables are preceded by chapters on the Morphology of Bacteria, on their cultural characters and bio-chemical functions, &c. With the use of the present manual we believe that the teacher can place a given culture in the hands of his pupil and expect him to determine it, as is done with other organic forms. We feel assured then that the present work will serve a useful purpose as a laboratory manual.

### THE POCKET GRAY. (b)

WHEN a book has reached its twentieth thousand there is little need to enter into any detailed notice of its merits. Yet this old friend, which has been revised and edited by Mr. C. H. Fagge, M.B., F.R.C.S., the Senior Demonstrator of Anatomy at Guy's Hospital, has some new features which are likely to add to the value of the work. The most important addition is that of the description of the action of each muscle, which certainly renders the account more complete. A book of this

(a) "A Manual of Determinative Bacteriology." By Frederick D. Chester, Bacteriologist, Delaware College, &c., &c. New York: The Macmillan Company. 1901.

(b) "The Pocket Gray, or Anatomist's Vade Mecum." Fifth Edition. Revised and edited by C. H. Fagge, M.B., F.R.C.S., Senior Demonstrator of Anatomy, Guy's Hospital. London: Baillière, Tindall and Cox. 1901. 3s. 6d. net.

kind is of use in refreshing the memory of the student or the practitioner on points that it is not easy to retain in the memory. That it fills a gap in the bookshelf of the student has long been attested by its steady and unflinching popularity. So far as we have been enabled to test its contents, we are pleased to find that Mr. Fagge has achieved that standard of accuracy so necessary in a book of this nature. Apart from surgery there is a constant necessity for reference to the facts of anatomy in purely medical work. The physician, for instance, has to keep in mind the nerve-supply of muscles and of cutaneous areas, and the anatomy of the brain. Indeed, it may be said that any practitioner of medicine, no matter what his particular branch, would do well to have a "Pocket Gray" on his study table for occasional reference. As to the student, there is no need to sing to him the praises of so old and trusty a friend. We are glad to see that neither publisher nor editor has yielded to the temptation to increase the size of the book.

#### OLIVER ON BLOOD AND BLOOD PRESSURE. (a)

DR. OLIVER'S instruments for the examination of the blood, for the determination of blood pressure, and the calibre of superficial arteries are here described, not, of course, for the first time. They have been included among the *arma scholastica* of teachers of physiology for some years, and from their first appearance have not gone without a welcome from competent and representative physiologists. Unlike many of the contrivances invented for the purposes of research in physiology they are the direct outcome of the desire of a physician to apply to his clinical practice new and exact methods of investigation. Devised for clinical use they have been systematically used now for some years by Dr. Oliver, as much as the stethoscope or thermometer have been used by other physicians. This book embodies the results he has obtained in this way. Scientific research in the course of clinical practice is sufficiently rare, much too rare, and that, it is safe to assert, not because it is discouraged by patients. Dr. Oliver's book is a lesson to clinical physicians in this; but it is not only on this ground that it is remarkable, the results at which he has been able to arrive are, many of them, of the greatest interest to medical men, whether engaged in research or practice. In Dr. Oliver's own branch of medical practice in balneology it marks an epoch.

### Laboratory Notes.

#### TYPHOID FREE OYSTERS.

It is high time the Merchandise Marks Act was made to apply to oysters, in the sense that it should be open to consumers of the delicious bivalve to be informed of the source from which the particular oysters they contemplate eating have been obtained. Were this generally possible public confidence would promptly be restored in a cheap and once popular article of food. The public have it on good authority that oysters grown in pure water may be regarded as perfectly safe, but this general proposition will not satisfy the fastidious or prudent customer in respect of an unidentified brand. His only alternative is to purchase oysters the origin of which he knows at first hand, and the life history whereof is a matter of public notoriety. Our attention was called some time since to the Clifden oyster beds which flourish on the coast of Connemara, co. Galway, "far from the madding crowd" and all the typhoid possibilities. We have now had an opportunity of looking into the matter, and the impression we have formed is decidedly favourable to the enterprise. The beds are situated in the Atlantic, in bays chosen on account of their physical advantages in respect of oyster culture, and are alimented at every tide by water fresh from the ocean. The fisheries are fully fifty miles from any important aggregation of human beings, so that contamination by microbes

(a) "A Contribution to the Study of the Blood and Blood Pressure." By George Oliver, M.D., F.R.C.P., &c. London: H. K. Lewis, 1901.

which are productive of disease in the human being is virtually impossible. The oysters themselves, samples of which we have microscopically and practically examined, are uniformly of excellent quality, and as the beds are only four miles from a railway station rapid transit ensures their delivery in a fresh condition. From a dietetic point of view the scientific culture of oysters under strictly hygienic conditions, the "open water" treatment of oysters, is an undertaking of extreme importance, well worthy of public support.

#### CASUMEN.

We have made an analysis of Prideaux's "Casumen," prepared by Prideaux's Pure Casein and Life Food Co., Ltd., Notcombe, Dorset, and obtained the following results:—

Casein ... ..	88.35 per cent.
Fat ... ..	2.92 "
Mineral Salts ... ..	2.81 "
Moisture ... ..	5.87 "
Sugar ... ..	nil
Starch ... ..	nil

This preparation of milk casein is a fine flocculent powder, free from taste and odour, and is quite soluble in water. The percentage of soluble casein being 88.35 per cent., proves beyond question that it is of the highest value as a flesh-forming food, and as it contains no starch or sugar it is eminently suitable for use in cases (diabetes, &c.), in which it is desirable to prescribe a diet free from carbohydrates.

There are a number of everyday foods, which, being deficient in nitrogenous compounds, are *pro tanto* deficient in alimentary value, but this shortcoming can now be easily remedied by the addition of a suitable proportion of "Casumen."

The value of decidedly soluble albumens to enrich the invalid dietary is now generally recognised and we anticipate that in the near future they will play an important and increasing part in the alimentation of invalids and persons with feeble digestive and assimilative powers.

### Medical News.

#### The Dawlish Libel Case.

At the Devon Assizes, last week, one Clara Cooper was tried on a charge of writing and publishing false, scandalous, and malicious libels concerning Dr. C. N. Lovely, of Dawlish. Medical evidence was given to the effect that the prisoner was insane and irresponsible for her actions, but she was sentenced to six months' imprisonment in the second division. Her mental condition will now come under the cognisance of the authorities. The prosecution was conducted by the London and Counties Medical Protection Society, of which Dr. Lovely is a member.

#### Assault by a Patient.

DR. AUSTEN, of Lingfield, Essex, was the victim of a violent assault last week at the hands of a patient whose mental condition he was investigating. Dr. Austen received a blow with a chopper, severing the tendons of the right hand and inflicting other severe injuries.

#### Small-pox in London.

EACH day continues to furnish its quota of recruits to the small-pox hospitals, varying in number from 30 to 15. On Monday evening the number of patients under treatment was 402. The vaccination returns for September and October in St. Pancras show that while the number of cases on the birth list was 1,082, the certificates of vaccination amounted to 2,080, so that the inhabitants are evidently making up for arrears. The total number of scarlatina and diphtheria cases show a slight increase, the present number of patients suffering from these diseases being 5,120.

#### Free Serums.

THE Blackpool Corporation has undertaken to keep a supply of serum for diphtheria and puerperal fever for gratuitous distribution. It is stated that, ultimately,

the serum, "for every disease known to medical science," will thus be rendered available—a rather tall order, and somewhat in advance of the times.

#### Deaths under Chloroform.

A MAN, age 31, died under chloroform last week while having some teeth removed, at Tarporley, near Manchester. Another death from the same cause occurred at Liverpool, the victim being an infant eighteen months of age, who was undergoing an operation for the remedy of cleft palate. Death in this instance was attributed to the passage of blood into the trachea, and an exonerating verdict was returned.

#### Serious Charge Against a Medical Man.

THE daily papers of November 19th report that Dr. John Flanagan, medical officer of Ballinalee district, and two other men, were brought up at Mullingar and remanded, charged with grievously assaulting Bernard Phillips, a groom, by throwing vitriol over the lower part of his body, thereby causing serious injuries in the abdominal region. It was alleged that the offence was committed on November 3rd, but the prosecutor did not give information until the end of last week. It was then found that the accused had absconded, and warrants were issued, and the arrests made in Dublin. Phillips was Dr. Flanagan's groom, and it is stated that the affair took place in the kitchen of the former's house at Longford.

#### Presentation to a Medical Man.

DR. BREW, of Enniskerry, has been presented by his friends, on the occasion of his marriage, with a magnificently chased silver salver. The salver bore the following inscription:—"Presented to Richard W. Brew, M.B., on the occasion of his marriage, October 9, 1901, in recognition of his valuable services to the poor and public, and the kindly and sympathetic manner with which he discharged his professional duties since his appointment as medical officer of this district."

#### A Serious Admission.

WILLIAM TYNDALE WATSON, Medical Officer of Health to the Tottenham District Council, pleaded guilty last week to an assault on a little girl, but in view of the medical evidence in respect of the prisoner's health sentence was postponed.

#### The Poisons Committee.

THIS Committee, appointed by the Lord President of the Council to inquire into what alterations may be expedient in Schedule A of the Pharmacy Act, 1868, sat at Whitehall on Tuesday, Wednesday, and Thursday last week, Sir Herbert Maxwell, M.P., in the chair. There were also present Mr. A. Cross, M.P., Professor T. E. Thorpe, Professor W. A. Tilden, Dr. Stevenson, Mr. W. Martindale, Mr. J. H. Harrison, and Mr. E. B. Masham (secretary).

#### A Medical Hero.

DR. WILLIAM SMITH, of Dungloe, Co. Donegal, has succumbed to typhus fever, contracted in the discharge of his duties as dispensary doctor, he having transported a patient suffering from the disease in a boat from the Island of Arranmore. By a mournful coincidence his predecessor met his death under exactly similar circumstances.

#### Royal Commission on Tuberculosis.

WE have received an official intimation that the Royal Commission on Tuberculosis is now sitting at 1, Chapel Place, Delahay Street, Westminster. The experimental part of its work will be carried out near Stansted, in Essex, on two farms that have been generously placed at the disposal of the Commission by Sir James Blyth.

#### Medical Temperance Association.

A MEETING of the British Medical Temperance Association was held in the Governors' Room of Guy's Hospital (by kind permission of the Visiting Committee) on Friday, the 22nd inst., at 4.30 p.m. Prof. Charters Symonds presided and the discussion, which was on the

"Advantages of Total Abstinence," was ably opened by Dr. Claude Taylor. Several students and others took part in what proved a most interesting and instructive discussion. Tea and coffee (provided by the kindness of the hospital authorities) were served during the half-hour preceding the meeting.

#### Further Medical Detachments.

ORDERS have been issued for another 100 men of the Royal Army Medical Corps to leave Aldershot for South Africa on the 6th prox., and three more detachments of 100 each by the beginning of January. This will make a total of over 700 in two months, the largest reinforcement in so short a period since the beginning of the war.

## Pass Lists.

#### University of London.

The following is an official list of candidates who have passed the M.B. Examination:—

First Division.—John Atkins, Hermann Balean, Janet Mary Campbell, Frank Challans, Carey Franklin Coombs, Alfred Ernest Jones, Henry Crewe Keates, Robert Kalsall, Robert Archer Lloyd, John Ford Northcott, Richard Horace Paramore, Arthur Bicketts, Charles Archibald Scott Ridout, William Morton Robson, Ellen Mary Sharp, John Henry Sheldon, James Ernest Stratton, Albert E. Thomas, Charles J. Thomas, B.Sc., Kenneth Vincent Trubshaw, John Frederick Walker, William H. Wynn, B.Sc., Ernest Eric Young.

Second Division.—Kenneth Bush Alexander, Alfred Eaton Baker, Robert Balderston, Ernest Gilbert Bark, Harold Shuttleworth Barwell, Anthony Birch, William Henry Bowen, Sidney Bree, John Charlton Briscoe, Henry Martyn Brown, Herbert William Brown, Katherine Chamberlain, Olive Claydon, Myer Coplans, Louis Edington Dickson, Arthur Edmunds, B.Sc., Benjamin Gregory Fiddian, Herbert Halliday, Helen Beatrice Hanson, T. Ayscough Hawkesworth, Helena Gertrude Jones, Ernest William Julius Ladell, Ernest Lewis Lilley, Edward Vaughan Lindsey, Thomas Lister Llewellyn, Kenneth Fraser Lund, Zebulon Mennell, Edwin Morgan, Bertram Wilmore Moss, Frank Herbert Noke, William Gibson Parker, William Edward Peck, Joseph Arthur Perdrau, Howard Welles Reynolds, Robert Ellis Roberts, B.Sc., Florence Robinson, Agnes Catharine Scott, Walter Bernard Secretan, Charles Gabriel Seligmann, Cuthbert Fennessy Selous, Harold Farley Seymour, Harold Weightman Sinclair, Anna Maude Smith, Douglas Wilberforce Smith, Alfred Richard Spencer, Louis E. Stamm, B.A., B.Sc., William Lumsden Stuart, John Herbert Sykes, Claude Tessier, Robert Cyril Turnbull, George William Watson, George Ernest Waugh, Augustus Joseph Wernet, Frank Cordeux Wetherell, Clarence Barns Whitehead, John Thomas Williams, Arthur Gordon Wilson, Edith Louisa Young.

#### Society of Apothecaries of London.

THE following candidates have passed the undermentioned examinations in:—

Surgery.—J. E. Bolton (Sections I. and II.), E. N. de V. Dawson (Section I.), E. Gauld (Section I.), W. St. A. F. Hubbard (Section I.), B. S. O. Maunsell (Sections I. and II.), H. S. McLellan (Section I.), D. V. Muller (Section I.), E. Rees (Sections I. and II.), C. M. Woods (Sections I. and II.).

Medicine.—C. H. Allan (Sections I. and II.), P. C. Burgess (Section II.), A. Dewar, P. S. Hopkins (Section I.), H. S. McLellan (Section I.), D. V. Muller (Section I.), B. E. Sansom (Sections I. and II.), F. I. Trimmer (Sections I. and II.).

Forensic Medicine.—C. H. Allan, J. H. Beasley, S. F. Cheesman, A. Dewar, P. S. Hopkins, C. E. A. Huddart, H. S. McLellan, B. F. Sansom, F. I. Trimmer.

Midwifery.—E. Gauld, H. S. McLellan, F. H. Rotherham.

The diploma of L.S.A. was granted to the following candidates:—C. H. Allan, J. H. Beasley, P. C. Burgess, B. S. O. Maunsell, B. E. Sansom, F. I. Trimmer.

## Notices to Correspondents, Short Letters, &c.

✉ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

DR. MAITLAND RAMSAY'S paper is marked for an early number.

DR. J. PERCIVAL BROWN (Manchester).—We cannot lend our columns for the purpose of criticising the conduct of another medical journal, however well founded your criticism may be.

CALCHAS.—1. The middle period of life is that in which locomotor ataxy usually commences. No less than half the cases begin between thirty and forty, one quarter between forty and fifty, and rather less than a quarter between twenty and thirty. It rarely begins after fifty, and still more rarely before twenty. 2. Males suffer far more frequently than females, the proportion being about ten to one, and this implies some proclivity inherent in the male sex. 3. One of the causes which can sometimes be clearly traced is injury, which involves concussion of the spine. 4. The symptoms appear to develop gradually some weeks or months after the injury. 5. One of the best modern text-books on the practice of medicine is Osler's "Principles and Practice of Medicine"; on Midwifery, Jewett or Galabin.

N. T. C.—The late Mr. R. B. Anderson left a wife and family in Tobago almost entirely, we believe, unprovided for. A Fund has been started by Lord Stamford, Mr. Timothy Holmes, and others, with a view to rendering them some assistance, but we regret to say that this effort has not met with much response. It will be remembered that Mr. Anderson was awarded £500 damages against a judge in Tobago, but this verdict was set aside at the High Court by the late Chief Justice Coleridge, and it was in pursuit of the endeavour to obtain redress for this injustice that Mr. Anderson came so much under public notice during the few years preceding his death.

LOMAX.—In modern times, perhaps, the most striking statistics of the beneficence of vaccination are furnished by the reports relating to the prevalence of small-pox in the Franco-German War. The mortality among the French was 23,500, and among the Germans, who had all been vaccinated, 268. These figures have never been disputed, and they can always be quoted in refutation of the misrepresentations of the anti-vaccinationists.

DR. M. W. Toxic symptoms as the result of absorption of belladonna from plasters are by no means unknown, indeed, they would probably be discovered, if looked for, in most instances of the application of such plasters if they exceed, say 20 square inches. Naturally the degree of absorption will depend upon the thickness or otherwise of the skin. As a rule, but slight inconvenience is caused unless there happen to be, or to form, a solution of cutaneous continuity.

## Meetings of the Societies.

LONDON.

WEDNESDAY, NOV. 27TH.

DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND (20 Hanover Square, W.).—5 p.m. Meeting.

HUNTERIAN SOCIETY.—(London Institution, Finsbury Circus, E.C.).—8.30 p.m. Pathological Evening.

THURSDAY, DEC. 5TH.

HARVEIAN SOCIETY OF LONDON (Stafford Rooms, Titchborne Street, Edgware Road, W.).—8.30 p.m. Mr. C. W. Mansell Moullin: Some Unusual Effects of Moveable Kidney.

FRIDAY, DEC. 6TH.

WEST LONDON MEDICO CHIRURGICAL SOCIETY.—Clinical Meeting at the West London Hospital, when Mr. Keetley, Dr. Seymour Taylor, Dr. Saunders, and others, will show cases.

DUBLIN.

WEDNESDAY, NOV. 27TH.

Dublin University.—Final Medical Examinations. Sections A and C, continued.

FRIDAY, NOV. 29TH.

Royal Academy of Medicine in Ireland. Section of Pathology.—Exhibits and Communications—1. Dr. Parsons: (a) Note on a case of Gastroectasis, (b) Aneurysm of Aorta. 2. Prof. O'Sullivan: Blood from case of Tropical Malaria showing Crescents. 3. Mr. J. B. Story: Zonular Cataract. 4. Mr. H. G. Croly: Sarcoma of Knee. 5. The President: (a) Remarks on the Causation of Vaccinia (with lantern demonstration), (b) The Bacteriology of a case of Suppurative Pelophlebitis secondary to a case of Appendicitis. (c) Huge Supra-renal Cyst.

Royal College of Surgeons. 8.30 p.m.

## Appointments.

AIRD, I., M.B., B.S. Edin., Certifying Surgeon under the Factory Acts for the Bangor District of County Down.

BARTON, G. A. H., M.D. Brux., M.R.C.S., L.S.A., an Honorary Assistant Anaesthetist to the City Orthopedic Hospital, London.

INGLE, C. D., M.R.C.S., F.R.C.P., Certifying Surgeon under the

Factory Acts for the Somerton District of the County of Somerset.

PARRY, LEONARD A., F.R.C.S. Edg., B.S., M.D. Lond., Assistant Surgeon to the Sussex Eye Hospital, Brighton.

PATERSON M. S., M.B., B.S. Durh., M.R.C.S., L.R.C.P., Resident

Medical Officer to the Hospital for Consumption, Brompton.

ROCHE, REDMOND, A.B., M.R.C.S., L.R.C.P., L.M., Attending

Medical Officer, Westminster Dispensary, Westminster.

SELKIRE, J. FREDERICK, M.B., Ch.B. Edin., House Surgeon to the

Chichester Infirmary.

## Vacancies.

County Asylum, Mickleover, Derby.—Senior Assistant Medical Officer. Salary commencing at £150; also Junior Assistant Medical Officer. Salary commencing at £120; both with apartments, board, washing, and attendance. Applications to the Medical Superintendent.

Devonshire Hospital, Buxton, Derbyshire.—House Surgeon and Assistant House Surgeon. Salary, House Surgeon £100 per annum, Assistant £50 per annum, with apartments, board, and lodging. Applications to the Secretary.

Dr. Steevens' Hospital, Dublin.—House Surgeon. Salary £100 per annum, with apartments, fire, and light. Applications with copies of testimonials, to be addressed to the Governors not later than December 9th. (See Advt.)

Down District Lunatic Asylum.—Assistant Medical Officer. Salary commencing at £150 per annum, with board, apartments, washing &c. Applications to be addressed to the Resident Medical Superintendent. (See Advt.)

Glasgow University.—Additional Examinerships in Medicine and Science, with special reference to Chemistry, Materia Medica, Zoology, Practice of Medicine and Surgery. Particulars as to dates emoluments, &c., on reference to our advertising columns.

Manchester Hospital for Consumption and Diseases of the Throat and Chest (In-patient Department, Bowdoin, Cheshire).—Resident Medical Officer. Salary £100 per annum, with board, apartments, washing &c. Applications to the Secretary.

North Staffordshire Infirmary and Eye Hospital, Hartshill.—House Surgeon. Salary £120 per annum, with increase, and apartments, board, and washing. Applications to the Secretary.

Owens College, Manchester.—Assistant Lecturer in Pathology. Stipend £150 per annum.

Royal Hospital for Incurables, Donnybrook, Dublin.—Resident Medical Officer. Salary £100 per annum, with board and apartments. Application to J. J. Thompson, Esq.

School Board for London.—Medical Officer. Salary £800 a year, rising to £1,000 a year. Forms of applications may be obtained at the Offices of the Board Victoria Embankment.

The Children's Hospital, Dublin.—House Surgeon. Salary £50 per annum, with apartments, &c. Applications to the Hon. Secretary. (See Advt.)

Wilts County Asylum.—Assistant Medical Officer, unmarried. Salary £150, rising to £170, with board, residence, attendance, and washing. Applications to the Medical Superintendent.

## Births.

DRABBLE.—On Oct. 22nd, at the Manor House, Walton-on-Thames, the wife of Geo. W. Drabble, M.B., M.Ch., of a daughter.

FERNANDES.—On Nov. 20th, at Ackworth, Yorkshire, the wife of R. W. L. Fernandes, M.B., C.M., of a daughter.

ROGER-SMITH.—On Nov. 21st, at 1, College Terrace, Hampstead, the wife of Hugh Roger-Smith, M.D., of a son.

## Marriages.

COOK—CLAYTON.—On Nov. 23rd, at All Souls' Church, Laughaugh Place, London, W., Joseph B. Cook, L.R.C.P., M.R.C.S., of Packington Street, Ilington, to Malvina (Millie), only daughter of the late Jesse Clayton, Esq., solicitor, of Ely, Cambs.

RYALL—COLLIER.—On Nov. 23rd, at St. George's Church, Hanover Square, London, Charles Ryall, F.R.C.S., youngest son of the late Ed. C. Ryall, Surgeon to the 18th Royal Irish Regiment, to Frances Mary, daughter of the late Thos. Collier, J.P., of Alderley Edge, Cheshire.

## Deaths.

CLIFT.—On Nov. 23rd, at Kno's Lodge, Tressillian Road, Brockley, S. E., Samuel Clift, Deputy Inspector-General, R.N. (retired), M.R.C.S., aged 78 years.

DOBIE.—On Nov. 23rd, at Townfield House, Keighley, Yorks, Wm. Dobie, M.D., J.P., aged 67 years.

HORROCKS.—On Nov. 16th, at Shoreham, Great Crosby, Lancs., Wm. Hy. Horrocks, M.R.C.S., L.S.A., aged 86.

LLOYD.—On Nov. 15th, at Amanford, Carmarthen, Evan Lloyd M.R.C.S., L.S.A.

MANLEY.—On Nov. 16th, at Cheltenham, Surgeon-General William G. N. Manley, C.B., V.C., M.R.C.S. Eng., Army Medical Staff (retired), in his 70th year.

MITCHELL.—On Nov. 13th, at Kinnehy, King's County, Adam G. Mitchell, L.R.C.P., L.R.C.S. Ed., aged 45.

STURGES.—On Nov. 16th, at Garta, Baird's Hill, Broadstairs, Montague James Sturges, M.D. Edin., aged 66.

SUTHERLAND.—On Nov. 19th, at 21, New Cavendish Street, London, W., Henry Sutherland, M.A., M.D. Oxon., M.R.C.P., second son of the late A. J. Sutherland, M.D., F.R.C.P., F.R.S., aged 59.



# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

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## Original Communications.

### NOTES ON A CASE OF SUPPURATING OVARIAN CYST, COMPLICATED WITH A LARGE INTRAPERITONEAL ABSCESS. (a)

By HENRY JELLETT, M.D., F.R.C.P.I.,  
Ex-Assistant Master, Rotunda Hospital.

THE following case is, I think, worthy of being brought to the notice of the Academy. It furnishes an example of a happily not very common complication of an ovarian cyst, and is for this and perhaps for other reasons of interest. Before proceeding to relate it I must mention that I am not alone responsible for the good results with which its treatment was attended, but that it was a case the major credit for which belongs to our late President, Dr. A. V. Macan, who was the first person to operate upon the patient.

CASE.—Mrs. K. D., *æt.* 38, was admitted to Sir P. Dun's Hospital, under the care of Dr. Macan, on July 27th last. The patient at the time of admission was in an extremely critical condition. She suffered from great pain over the abdomen, loss of appetite, thirst, vomiting, extreme constipation, and debility. These symptoms had been present to a marked degree for the previous five weeks, but prior to that time she stated that her health had been fairly good. Her temperature on admission was 101° F., and her pulse varied from 100 to 120. On examination, her abdomen was found to be distended, owing to the presence in the lower part of a large and tense tumour, in the upper part of distended intestines. By vaginal examination, a tumour could also be found filling Douglas' pouch. The patient was kept under observation for a few days, and attempts made to secure an evacuation of the bowels. As, however, there was no improvement, but rather a deterioration in her condition, Dr. Macan determined to open the abdomen. On July 31st, he accordingly operated upon the patient, a proceeding at which he kindly invited me to assist. On opening the peritoneal cavity, it was found that the tumour was formed by a very large and very fetid collection of pus among the intestines. The collection extended upwards to slightly above the umbilicus, and downwards to the bladder, and the upper portion of Douglas' pouch. There were, as is usual, several loculi in which further and equally fetid collections of pus were found. With considerable difficulty all the contents of the abscess were evacuated, and the cavity was washed out and plugged from above with iodoform gauze. The abdominal wound was then closed

save for a portion of the lower end, through which the gauze emerged. I may mention that towards the end of the operation the advisability of draining from the vagina was discussed, and with a view to making the necessary opening, Dr. Macan asked me to pass my fingers into the vagina in order to determine the direction in which an incision should be made. However, when I had done this, we found that the collection of pus had not extended to the bottom of Douglas' pouch, inasmuch as the latter was occupied by a swelling the size of an orange, anteposed to which was the uterus. The condition of the patient at this time was so bad that it was determined not to remove this mass, but to trust to drainage from above. This decision I consider to have been very wise, as the further manipulations which its removal would have entailed would quite possibly have been sufficient to turn the scale against the patient.

The condition of the patient after the operation was very critical. She suffered much from vomiting, her pulse was weak, and her temperature sub-normal. She, however, was able to take small amounts of liquid nourishment, and on the second day after the operation her bowels acted. On August 3rd Dr. Macan went for his holidays, and the patient came under my care. She was then, to my mind, in an extremely bad condition, as a consequence of toxic absorption from the abscess. Her pulse was very feeble, and her temperature varied from sub-normal to 101° F. Her skin was jaundiced, her eyes sunk in her head, and her mind wandering. Further, it was difficult to induce her to take nourishment. The wound had been dressed twice daily since the operation, and the cavity douched out and plugged lightly with iodoform gauze. In spite of this, the smell of the discharge was still most offensive. As the solution with which the cavity was douched did not seem to produce any good effects—I believe that lysol had been used, I desired the nurse to inject instead a 25 per cent. solution of sanitas in warm water, and to wash out the cavity still more frequently than she had been doing. I had, however, very little hope of effecting a good result. The next day the patient was slightly better. The day after her condition was again improved, and the discharge was losing its extreme fetor. This gradual improvement continued, until, by August 8th, the temperature had fallen to almost normal. At the same time the abscess cavity was becoming notably smaller, and in a few days more it was possible to dispense with all plugging.

I may mention, incidentally, that in consequence of the infection of the abdominal wound by the contents of the abscess, all the sutures had cut out, and the entire wound, save for what was apparently a peritoneal floor, had reopened. As a result of the distended condition of the intestines, to which I will presently refer, this gaping became very marked, and must have measured as much as two inches across.

(a) A Paper read before the Obstetrical Section, Royal Academy of Medicine, Ireland. November 22nd, 1901.

Accordingly, as the condition of the patient was daily improving, I determined to bring together the edges with sutures. This I tried to do on August 19th, the sutures being passed subsequently to endermal injections of cocaine. In consequence, however, of the extreme thinness of the walls, and of the flaccidity of the skin, it was impossible to obtain a firm suture-hold of anything save the skin, and even then the main result of the sutures appeared to produce an inversion of the latter. However, the results of the re-suturing were not so bad as they appeared, the wound was immediately diminished by about half its width, and this was subsequently again further diminished by straps of adhesive plaster pulling over little rolls of cotton wool placed in the wound to keep the skin from inversion.

Unfortunately, the great improvement which had taken place in the patient's condition proved to be only temporary, and about September 1st she showed signs of returning to her former state. Her temperature again rose, reaching a height in the evening of 101° F., her appetite was lost, the abdomen became very tympanic, and it was almost impossible to get the bowels to move. I then examined the abdominal wound very carefully, but could find no sign of any accumulation of pus in its neighbourhood. The small sinus which a few days previously had lead to the former site of the abscess cavity, was almost completely closed. It appeared to be in every way healthy, and there was no evidence of any accumulation of pus around or below it. Accordingly, I made a vaginal and rectal examination, and was then easily able to determine the presence of a swelling completely filling Douglas' pouch, pressing upon the rectum, and obviously containing fluid. It was apparently larger than at the time of the operation.

As this swelling was obviously the cause of the patient's condition, I determined to remove it with as little delay as possible. Accordingly, on September 5th, five weeks after the first operation, with the assistance of Dr. Kennan, I opened the posterior vaginal fornix in the usual manner. On reaching Douglas' pouch, I found that my finger came into contact with a well-defined tumour, adherent to the neighbouring structures and containing fluid. The adhesions to the floor of Douglas' pouch could be easily broken down, but, when the finger came to the upper portion of the tumour, they were found to be very dense. Whilst breaking these down, a portion of the tumour was torn and a quantity of very foetid pus escaped. With some little difficulty the entire tumour was separated from its upper attachments, and remained alone attached by what was apparently a pedicle connecting it with the right cornu of the uterus. There was no trace of any structure resembling the pelvic-infundibulo ligament. As there was a considerable amount of hæmorrhage from the broken down adhesions and possibly from the remains of this ligament, I applied a clamp to the pedicle, divided the latter, and removed the tumour. Then, as there was no bleeding point to be seen, but a quantity of general oozing, I plugged the pelvis with gauze sponges wrung out of water at a temperature of about 115° F., taking care not to disturb the clamp. The following day I removed the sponges, a process which necessitated the administration of nitrous oxide gas. I had not intended to remove the clamp until the following day, but it came off in the process of re-plugging the pelvis, the reason for which was subsequently made very obvious. There was, however, no hæmorrhage. There is little more necessary to add. I re-plugged the pelvis each day through a glass speculum, inserted through the opening in the vaginal fornix. For the first few days, it was necessary to administer an anæsthetic, as the patient could not bear the pain which the proceeding caused. Each day the

cavity became a little smaller, the patient's temperature gradually fell to, and then remained at, normal, and her condition materially improved. About the middle of September Dr. Macan returned, and I resigned her to his care. She continued to improve steadily from day to day, and on November 10th she left the hospital.

The history of the clamp, which fell off, is not uninteresting. It was given to the nurse to wash, and as soon as it was placed in warm water one blade fell off. It had apparently cracked half across at the lock during the application, and then completely across whilst it was *in situ*. The dried blood with which it was covered had, however, proved sufficient to hold it together. The clamp had been made in Germany. The moral is obvious.

There is one point which this case shows very clearly, and that is the amount of foetid pus which can be present in a patient without interfering with the temperature, when once she has become so to speak inoculated against such pus. In this case, after the patient had recovered from the first operation, her temperature fell to normal, and remained so for seventeen days. Yet all the while, there was an accumulation of most foetid pus in the pelvis.

The action of sponges wrung out of very hot water in checking what was a considerable amount of hæmorrhage, was most satisfactory. Their temporary use had been suggested to me by Dr. Glenn in a previous case, where they had also succeeded admirably. In this case they were allowed to remain as a substitute for iodoform gauze, and were removed without difficulty on the following day.

The cause of the large abscess which Dr. Macan opened, seemed to be very obscure at the time of his operation. There was a collection of pus among the intestines, apparently unconnected with any tangible source of infection. The discovery subsequently of the suppurating ovarian cyst will, however, I think explain its origin. To my mind, the case was originally one of an ovarian cyst, the pedicle of which became twisted. The contents of the cyst were then infected from the rectum, and this infection extended in turn through the walls of the cyst into the peritoneal cavity setting up a localised peritonitis, and ultimately leading to the formation of a large abscess.

## French Clinical Lecture.

### TREATMENT OF DIABETES.

By Dr. LEPINE,

Professor Agrégé at the Faculty of Medicine of Lyons.

FIRST of all, and before dealing with the treatment, it is necessary to question the patient closely on his mode of living. Men are frequently bad observers of themselves, and it is necessary to verify their assertions by appealing to those who live with them, especially their wives. In this way certain important particulars, harmful habits and the like, may be discovered. Last year I was consulted by a diabetic patient, æt. 50. He was free from every hereditary taint, and led a very sober life. After long questioning I found out that he had been living at one time three miles from his place of business, and had walked the distance four times daily, doing thus regularly twelve miles. A few months before coming to consult me he came to live at his place of business, and consequently was deprived of his hygienic promenade. I prescribed two hours' walk a day, and naturally ordered some restrictions in his diet, and the glycosuria disappeared.

After correcting hygienic defects of the patient the medical examination commences—hereditary and personal antecedents, actual condition, &c. After

these investigations we pass on to the state of the urine, how much sugar? What kind of sugar? Are there other anomalies of the urine, notably albuminuria, renal casts? Does the urine give the reaction of Gerhardt (port wine colour when perchloride of iron is added).

The determination of the quantity of sugar excreted in the twenty-four hours is of value only when it is exact. The sample of urine to be tested should not be taken at any hour of the day but from the total quantity of urine emitted in the twenty-four hours; further, it is well to put the patient for two or three days on his ordinary diet. The quantitative analysis of sugar should be made both by the polarimeter and by the aid of Fehling's solution, the one controlling the other. After estimation of the sugar we next ascertain the proportion of urea, as it is necessary to know the degree of disassimilation of albuminoid foods. In this respect it is too frequently forgotten that all men are not equal; there are big and small, fat and thin, old and young. To compare the urea with the body weight, as is sometimes done, is good as far as it goes, but it is not sufficient; if a precise estimate is to be made it is indispensable to compare it with the quantity of fixed albumin contained in the body of the subject.

The proportion of sugar to urea is not without interest. Let us take a patient with diabetes—that is to say, one who fails to burn up the sugar which he forms at the expense of the albuminoid elements, and who states that he is following a strict anti-diabetic regime. If the proportion of sugar to the urea is five or six of sugar to one of nitrate of urea, then either the patient does not observe strictly his regime or the diabetes is very grave.

Albuminuria is very common in diabetic patients. This fact, insisted upon by M. Stokvis (1886) is too little known by physicians, because they generally consider a little albumen as of no importance. But the outcome of investigations made by Külz and Von Noorden tends to prove that in two-thirds at least of the cases albumen was present, and in a large number of these cases (60 per cent.) renal casts were also seen, revealing the existence of renal irritation. This latter symptom is important in the treatment of diabetes, because where a large number of casts is present any remedy capable of irritating the kidney should be avoided, nephritis, however slight, being one of the most favourable conditions to the development of premonitory intoxication of coma.

The urine of healthy individuals may contain traces and sometimes a rather larger proportion of acetone, consequently it is not acetonuria but diaceturia that must be looked for in diabetic patients, because it affords the surest indication of the condition of the patient. Nothing, on the other hand, is easier than the detection of diaceturia; it is sufficient to add a little perchloride of iron to the urine. If the mixture turns the colour of port wine, the urine contains diacetic acid. This is the reaction of Gerhardt.

The presence or otherwise of this acid is of the utmost importance in regard to the prognosis of the malady. As long as there is no acid the treatment may be limited to suppressing the glycosuria by a strict regimen and appropriate medical treatment, but if diacetic acid be present the glycosuria passes into the back ground, and all our efforts should be concentrated on the removal of the acid.

*Treatment of diabetes where diacetic acid is absent.*—(a) Diabetes in which the glycosuria disappeared even under the influence of a prescribed regime. The first thing to do is to submit the patient during three days at least to a regime consisting of albuminoid and fatty substances, meat, fish, cheese, cream, eggs, walnuts, &c. But in order that the experiment should be of any value, it is necessary to

take into account the quantity of food daily ingested. It is also absolutely necessary that the regime be sufficient to maintain the nitrogenous equilibrium of the patient, for though a starvation diet is very effectual against the sugar, it is not very practical, because in suppressing the glycosuria it may kill the patient. On the other hand, an excess of albumen would be very injurious, consequently the nourishment should be just sufficient, taking into account the weight of the patient, whether stout or thin, &c. If, thanks to this regime, the sugar disappears, the patient may be considered to have a mild form of diabetes and should no complication arise the malady may be regarded as benign.

(b) Diabetes in which the glycosuria is merely diminished by the regime.

Here the treatment is more difficult, since even with a strict diet the sugar is merely diminished in quantity, and not got rid of altogether. In such cases the strict meat diet has been highly recommended, but in spite of Cantini's authority, I do not hesitate to affirm that this practice is dangerous, as it has a tendency to irritate the kidney and to increase the albuminuria, and in some cases it increases the glycosuria by rendering the kidney more permeable to sugar. The reality of renal diabetes is, however, not generally admitted as yet, but it is beyond doubt that we must even now accept the existence of a renal element in diabetes. In other words, of two patients with the same degree of hyperglycæmia will excrete urine containing but little sugar, and the other a great deal because their kidneys are unequally permeable; a fact, which clinical experience shows us every day.

*Treatment of Diabetes with Diacetic Acid in the Urine.*—It is hardly necessary for me to recall the fact that diabetic patients whose urine contains diacetic acid also excrete acetone. We meet, however, with many persons who excrete a small quantity of acetone without any appreciable diaceturia, but there does not exist, to my knowledge, diaceturia without acetone. More frequently, if not always, these patients have also oxybutyric  $\beta$ -acid in the urine.

As to the origin of these substances, there is still a great deal of uncertainty. Some years ago it was thought that the albuminoids were the exclusive source, but the researches of Geelmuyden seem to prove that fatty matters are a very important source of oxybutyric acid and its derivatives, diacetic acid and acetone, hence the indication for diminishing the ingestion of fatty substances.

Although in certain diabetic patients diaceturia may persist for months without any apparent inconvenience; the indication is absolute, viz., to arrest this grave complication. Everything should be brought to bear on this important point. The means at our disposal are by diet and suitable medication.

Free ingestion of carbo-hydrates is frequently followed by a decrease of diaceturia. That is an important fact, but it cannot entirely satisfy us, because, on the other hand, the glycosuria is increased. Consequently, it is necessary to find some other substance. Schultzen, a long time ago, thought that he had found this substance in glycerine, his belief being based on the theory that the sugar by absorbing an equivalent of water was converted into glyceric aldehyde and glycerine. Unfortunately experience did not bear out this seductive theory.

According to M. Schwartz, a derivative of glucose, gluconic acid, that is to say, glucose already in part oxidised, would diminish the diaceturia better than the glucose, and, in fact, the case published by M. Schwartz is worthy of attention. It was that of a

young man suffering from grave diabetes with pulmonary phthisis. During the six weeks of his sojourn in the hospital of Prague the patient fell three times into a comatose condition, with increase of excretion of acetone. The first time, and while he had been already unconscious, he was given, in a pint of water, 70 grammes of gluconic acid, neutralised by 140 grammes (five ounces) of bicarbonate of soda of this last substance being given by the mouth and by the rectum. Although the acidity of the urine persisted, the patient recovered consciousness; the dyspnoea, which was very marked, disappeared, and the condition of the patient remained satisfactory for three weeks; but the increase of fatty food, augmented again the acetone, and a second attack of coma was the result; similar treatment was ordered, and for fifteen days all went well. He had, however, a third attack, and this time he was treated exclusively by bicarbonate of soda, gluconic acid being unobtainable, but he succumbed the third day of the coma.

It is evident that in this remarkable case gluconic acid saved the patient twice. It seemed to have acted as a genuine curative agent. However, it is impossible to base any conclusion on an isolated case, and it is to be hoped that we shall soon have a sufficient quantity of gluconic acid to experiment with, not only in coma but also in the acid dyscrasia, before the appearance of the typical dyspnoea.

Until that time, however, we must always have recourse to bicarbonate of soda in very large doses; is in any case a very useful medication, and has saved many patients.

#### A NOTE ON THE MODERN TECHNIQUE OF POSTERIOR VAGINAL CÆLIOTOMY. (a)

By E. HASTINGS TWEEDY, F.R.C.P.I.,  
Ex-Assistant Master, Rotunda Hospital.

THE specimen I have the honour of presenting to your consideration this evening consists of the right Fallopian tube and a parovarian cyst removed from a very stout patient of mine in Steevens' Hospital, by the operation known as Prior's posterior vaginal cœliotomy. Prior's operation does not appear to have received the attention it deserves either in this country or yet in England, and it is for the purpose of eliciting the views of members here to-night concerning it that I now present this very common-place specimen. With a few exceptions Irish surgeons seem to have made incision into the anterior fornix their operation of election when performing colpotomy, and there does not appear any indication that the operation is advancing in popular favour, or even holding its own.

The objections urged against it are, that the limited opening into the abdominal cavity does not permit of the various steps of the operation being seen, consequently irreparable harm may be inflicted on important structures, which neither the sense of touch, nor a previous knowledge of anatomy can safeguard.

I believe we possess in Prior's operation a means of overcoming these, and other objections, to a considerable extent, provided conditions be favourable; or, in other words, provided a woman has borne a full-term child, and the vagina be not inflamed or abnormal.

In the removal of this tumour I followed his procedure, which I shall now describe in detail. The patient, a very stout woman, with a roomy vagina, was prepared as for an ordinary abdominal section, anaesthetised, and then placed on Burndt's operating table, in the usual dorsal position. The shaved vulva and the vagina were now for the second time scrubbed thoroughly with soap and water (green soap is to be preferred), then douched out with creolin solution, and finally bathed in an alcoholic solution of biniodide of mercury (1 in 1,000). This latter antiseptic is the one now most relied on in Steevens' Hospital for the final stages of skin disinfection. It has not alone the merit of great penetrability, but likewise hardens and cornifies epithelium, so hindering maceration and its removal during the operation. A bullet forceps was then attached to the posterior cervical lip, and the fornix exposed by means of a Martin's speculum. On moving the cervix up and down, the crescentic fold, which indicates the reflection of the vagina on to the cervix was clearly made out. This I picked up by a forceps, and incised the vaginal mucous membrane to the extent of about an inch, in the transverse direction, by means of sharp pointed scissors. This incision did not go deeper than the mucous membrane. A catch forceps was then fixed on the posterior flap, and my assistant was directed to make firm traction on this, as well as on the forceps attached to the cervix. My index fingers were now inserted into the wound, and tore with ease through the peritoneum, close to its uterine reflection. Before withdrawing the fingers the wound was enlarged by lateral tearing. This procedure is easily carried out, and does not involve fear of injury to the ureters, nor to the uterine vessels, provided undue force be not employed. The fingers having been withdrawn, a gauze wipe wrung out in saline solution, and to which a piece of silk is attached for ease in its removal, was now placed in the abdominal cavity to collect blood or other discharge, and to partially shut off the intestines from dust infection.

The next step of the operation consisted in the passing of two long vaginal retractors into the wound, and the removal of all other instruments from the vagina. The table was now lowered, so that the patient with her knees still in the gynaecological crutches, assumed the "head downward" or Trendelenberg position. On now widely separating the retractors the intestines could clearly be observed as they slowly receded from the field of operation, and an excellent view of the cyst—in size about that of a billiard ball—was obtained. The anterior blade was now removed, and the tumour seized by a couple of fingers presented no difficulties in its removal. The patient, raised again to the horizontal position, had the temporary pad removed, a strip of moist iodoform gauze was inserted just within the lips of the wound, and the vagina well packed around the fornices with similar material. This packing was taken out on the third day, the patient being under the influence of chloroform, and lying in the Sim's position. A new one was inserted, but not through the wound, this being a departure from the original operation, which provides for a drainage for seven days, an unnecessary precaution to my mind.

Dilatation of the sphincter, and the passage of a catheter every four hours are further suggestions the soundness of which will not be called in question.

The operation as thus described is a simple and rapid procedure, and remarkably free from complications. It is obvious that it possesses a wide range of usefulness, but as the indications for its employment are now sufficiently well known I need not dwell on them. As a means of gaining access to, and a greater knowledge of, the structures on while

(a) A Paper read before the Obstetrical Section of the Royal Academy of Medicine in Ireland, on Nov. 22nd, 1901.

we intend to operate, I believe it to be far superior to the older operations. With it injuries to the rectum should be avoided, while adhesions can be attacked, and separated with as much ease, and with far less danger, than if dealt with by means of a supra-pubic incision. Moreover, should the bowel give way while endeavouring to combat adhesions, the accident is not likely to prove of a very formidable character. The general peritoneal cavity is almost certainly shut off from infection, and the rupture, even though unclosed at the time of operation, will heal spontaneously in the majority of instances. I hold that all recent cases of pyosalpinx, which call for operative interference, should, when possible, be approached through the vagina. Multiple incisions into the abscess cavities, with subsequent drainage; the whole procedure, guided by sight and touch, even though it fail to effect a permanent cure, will at least render any more radical operation afterwards undertaken comparatively safe.

I trust I shall not be understood as saying that the operation just described marks any radical departure in vaginal cœliotomy. I am aware that posterior colpotomy has been performed very frequently by different surgeons in this city who can testify to the easy manner in which tubes and ovaries, even though normally situate, can be palpated and directly examined by its means. My contention merely is that Prior's operation makes a step forward in its technique, and somewhat enlarges its scope. Furthermore, it is obvious that anterior colpotomy must of necessity remain the proper operation under certain conditions. Finally, I should like to point out the great advantage afforded by modern operating tables, giving as they do a good Trendelenberg position, without which Prior's operation becomes impossible of execution. And of scarcely less importance is a sufficiency of light hardly procurable in any but the recently built operating theatre, of which we possess a very good example in Steevens' Hospital.

## The Harveian Lectures, 1901.

### TWENTY-FIVE YEARS' EXPERIENCE OF

### URINARY SURGERY IN ENGLAND.

DELIVERED BEFORE THE HARVEIAN SOCIETY OF  
LONDON, NOVEMBER 21st, 1901.

By G. BUCKSTON BROWNE, M.R.C.S.Eng.

#### ABSTRACT OF LECTURE III.

THE most important of the complaints which particularly concern the male urethra is certainly urethral stricture, especially when we consider the really fearful methods of treatment in vogue during the early part of the last century, and the dangerous operations to which patients were subjected, and which even now linger among us. The treatment of certain disorders of the urethra have been so modified and changed that urethral strictures are undoubtedly less severe than they were, and less frequently met with, and when met with are so much better treated that the modern stricture patient, if he is willing to submit to a very mild and gentle discipline, may usually view his future with perfect calm and equanimity. Strictures of the urethra may clinically be divided into two great classes—those which readily yield to dilatation and which can be kept open by the easy and periodical introduction of a bougie, and those which cannot. It is this latter class of stricture which I propose to consider to-night—that is, those which do not yield

to dilatation. It may be asked why should anything more be done if a patient can manage to make his water, and if his stricture will admit a small bougie? Apart from the constant danger of complete retention of urine, there is always the possibility at any moment of a urethral abscess, which is probably at first a peri-urethral abscess, with all the subsequent dangers and troubles of urethral fistula, and even if no abscess forms, it is certain that in time serious vesical trouble will arise, the bladder may as it were give up the struggle and become atonied, or it may become inflamed, contracted, and intensely irritable, the kidneys will become pyelitic, and finally there will be interstitial nephritis, suppuration, and death. If, in a case of stricture, a bougie as large as No. 8 or 9 (English scale) cannot be regularly passed, and passed with ease and comfort, something more radical must be attempted, and this more radical treatment has very much occupied the minds of surgeons for the last fifty years.

The history of the exact inception of internal urethrotomy is a little obscure, but it is certain that in 1827 an English surgeon, Mr. Stafford, of London, first brought forward his urethrotomes, which are undoubtedly the prototypes of all later instruments. About 1865 the forcible rupture of stricture, generally called Holt's operation, attracted a good deal of notice, the operation consisted in passing through the stricture a small railway, along which a metallic wedge was suddenly pushed in with considerable violence, and the fibres of the stricture ruptured. I often saw this done in my early days. It was an operation founded upon thoroughly unsurgical principles, and practised by those who would have had no sympathy with the views of the real nature of urinary fever, which I enunciated in my first lecture. I hope and believe that the operation is now dead, and thoroughly forgotten. Then in the late seventies came the treatment of stricture by electrolysis, it was introduced with great *eclat* at one of our London societies. I think some fifty cases at first were published, and every one was said to be perfectly successful, there was not a single failure among them all. I pointed this out at the meeting as a suspicious sign, but the treatment was taken up vigorously, and papers and books, full of successes, were published by surgeons of position. Where is the treatment now? Of all these treatments internal urethrotomy is the operation which I believe has come to stay. It is in my opinion the one treatment for all strictures which will not yield to dilatation. I will briefly state what I mean by internal urethrotomy. I mean the free division—no scarifications, no nicks, no multiple incisions—but one bold free stroke of the knife through all the fibres of the stricture in the floor of the urethra, since almost invariably the induration is most marked there. I maintain that this can only be done by an instrument which becomes practically a long knife in the operator's hand, and which is entirely under the control of that hand, subject to no mechanical restraint whatever, and cutting, much or little, when and where, just as the surgeon's tactile sense informs him is necessary. I prefer to cut from behind forwards, or from left to right, and the instrument which permits of this, and at the same time is simply a knife and nothing more, is the urethrotome usually credited to Civiale, and always recommended and used by Sir Henry Thompson. The blade is protruded beyond the stricture, and then drawn forwards, the stricture divided, the blade then sheathed, and the instrument withdrawn. It is difficult for me to express in sufficiently moderate words my disapproval of such an instrument as Maisonneuve's, which still figures in our text-books, and may be taken as the type of instrument pre-

ferred by those who would make surgery anything but what it ought to be, namely, a handicraft. Before, however, a Civiale's urethrotome can be introduced the stricture must be dilated up to at least a No. 6, and I have found in practice that it is always possible, after having passed a No. 1, to do so, indeed I can only recall one case where this was difficult, it is, however, "le premier pas qui coûte," and this leads me to the question of the treatment of different strictures, strictures which do not come to the surgeon until instrumentation is, if not apparently impossible, at least very difficult. In ordinary practice, if a patient in such a condition have complete retention of urine, the aspirator will probably be used, and it may be used several times, and still the stricture be found impassable by instruments. Symes said, and I entirely agree with him, that puncture of the bladder for retention of urine is fully warranted in military, naval, and country practice, but "when hospital surgeons confess that they frequently find it necessary to puncture the bladder, the standard of professional skill is lowered to a degree which may prove injurious to the interests of the public." After aspiration of the bladder contents and continued failure to pass a catheter, *per vias naturales*, the modern surgeon will usually perform a perineal section, usually after Mr. Wheelhouse's method, by this operation he exposes the anterior face of the stricture by a free perineal incision, and hopes to find the orifice of the stricture with his probe. If he finds the orifice, a director is introduced, and the stricture is divided by a knife and a catheter tied in. But the orifice of the stricture cannot always be found; the most consummate craftsmen have failed. If the stricture orifice cannot be found the operator makes a hit-or-miss incision, hoping to find the urethra behind the stricture. Is it surprising that incisions made in this way sometimes refuse to heal? I have gradually become imbued with the belief that in cases of difficult stricture the perineum must on no account be interfered with. This has led me slowly to discover for myself that *there are no cases of stricture, however severe, through which it is impossible to pass an instrument.* This is going further, then, than the dictum of Syme, who said that where water came out an instrument ought to go in. In making this statement that all strictures are passable by instruments, whether water comes through or not, I desire to speak with great care and deliberation, for I believe that the prevention and the mitigation of such human suffering depends upon belief in this doctrine. Of course, I must exclude from consideration all cases where the urethra has ceased to exist, the result of mechanical or pathological injury, and I know well that I am not in accord with many well known authorities.

Believing that an instrument, with care and patience, can always be passed through a strictured urethra, I next assert that when once an instrument has been fairly passed into the bladder, it can boldly be withdrawn and replaced by one a size larger if the surgeon have confidence in himself, and, thirdly, I have never yet met with a stricture which in this way could not be dilated up to No. 6 or 7 English. A Civiale's urethrotome can then be introduced and the stricture divided. This is what I term my method of internal urethrotomy *tout d'un coup*, at one operation. The worst case of stricture may be anaesthetised, dilated up to No. 6, the urethrotome introduced and the stricture cut to full size, and left with a full-sized catheter tied in, all at one sitting. Let us now consider the exact manipulation, we will not say of an impassable stricture, but of a very difficult one. In dealing with a difficult case of stricture, I have long ago given up the use of filiform bougies; their use is not true surgery; it is simply blind

groping and trusting to good fortune, whereas the surgeon should rely upon himself—that is, upon his sense of touch. Filiform bougies are really dangerous. When actually in the bladder they may break and lead to very unpleasant consequences. Filiform bougies are misleading also; no one can be sure where they really are, they may double up and really penetrate no distance, or they may pass into fistulae or false passages. I regret to find that they are still recommended in the latest works on surgery.

In the passage and dilatation of really difficult strictures I have no confidence in any instruments except steel ones. No silver catheters are strong enough, and I have even given up using the probe-pointed silver catheter of Syme, which for a long time was a favourite of mine. I prefer finely-polished rigid steel instruments, instruments which will not bend or yield under any proper force, and therefore allow of the most exact and accurate manipulation. I employ a set of sixteen sounds, each one is two sizes larger in the shaft than at the point, the smallest being No. 2 in the shaft and less than No. 1 at the point (marked 0-2), the next being 3 in the shaft and 1 at the point (marked 1-3), and so on up to the largest No. 17 (marked 15-17).

The treatment I have devised for all cases of difficulty or so-called impassable stricture is as follows, and I would first of all advise that the surgeon should arrange for a convenient time, when he is as free as possible from harassing calls and messages. It is no use, indeed it is dangerous, to attempt a bad case of stricture in a hurry. The instruments required are the sounds just mentioned, a Civiale's urethrotome (I always carry two in case of breakdown), some blunt-ended English gum bougies, varying in size from No. 3 to No. 10, a foot rule marked in inches, and a No. 11 or No. 12 soft gum catheter mounted on a stylet for tying in at the close of the operation. The patient (except in a case of acute retention) has been carefully prepared, aperients administered, a bath taken, and the rectum cleared by a good enema. If an operating table be not available, the bed should be made firm and level by placing the leaf of a table or a board under the mattress. Each leg of the patient is wrapt in a blanket, and a third blanket is placed across the body; the perineum and pubes are thus left exposed. The patient is then completely anaesthetised, for the urethral reflexes are the last to be anaesthetically abolished, and success depends upon the patient being perfectly quiet. A blunt-ended soft bougie is now introduced into the urethra, and the exact distance of the stricture, or in case of multiple stricture of the anterior stricture, from the external meatus is accurately ascertained and measured. In very difficult cases the right-handed surgeon will have to stand on his patient's left, and with his left finger in the rectum he will steady and secure the point of the well-warmed and vaselined steel sound as, holding it in his right hand, he attempts to pass it. The finger in the rectum will be at once informed if the point of the instrument leave the middle line. No force must be used, but a steady search made for the orifice of the stricture, and firm but gentle pressure exerted when found. The surgeon must steal in little by little, as Ambroise Paré says, referring to another subject. The operator will find after a while that the stricture yields under his hand, the instrument advances a little, and soon he is gratified by feeling the end of the sound fairly grasped by the stricture. At this moment no attempt should be made to pass the instrument, which is probably the 1-3, or next to the smallest, on into the bladder, at any rate not unless it passes forward quite easily, but it should be withdrawn and the next largest one, the 2-4, applied, and then the 3-5, by so doing the orifice of the stricture will be

dilated, and will not grip and retain the point of the 1-3, which may be taken up again, and will now probably pass on into the bladder. Then the 2-3, then 3-4, the 4-5 and the 5-6 should be successively passed in. The sounds are known to be in the bladder by their shafts being felt to be accurately in the middle line, and their points free in the bladder. When once the No. 6 or 7 sound has been fairly passed into the bladder, it should be allowed to remain in place, while the surgeon changes sides. He now stands on his patient's right, draws out the sound and slips in the urethrotome. If difficulty be found in introducing the urethrotome, the sound must again be passed. Sometimes the urethrotome can best be lightly and gently shaken in, as it were, rather than actually directed and passed in. When the bulb of the urethrotome is fairly in the bladder, there is a sensation of looseness and freedom quite characteristic, and the surgeon may feel sure that all is right. Nothing should be attempted until the surgeon is satisfied that the urethrotome is really in the bladder. When in proper position the instrument is carefully withdrawn until the bulb is an inch beyond where the stricture is known to begin, the anaesthetist is warned that the patient must be perfectly still for a moment, the blade is then protruded, and a free incision is made from behind forwards for a good inch along the floor of the urethra, and about half of an inch deep. The blade is then sheathed and the instrument withdrawn. A full-sized sound is now passed, a No. 12 or 13, and if, as is practically always the case, it passes easily, then the larger ones, 14, 15, 16, 17, may be passed in succession, and then the soft catheter mounted on a stylet, curved so as exactly to correspond with the curve of the sounds, is passed in, the stylet removed, and the catheter tied in. The urine which is in the bladder will issue by the catheter, and so show that all is right. Should there be a doubt about the catheter being in the bladder, it should be withdrawn and again passed in, and on no account should any water be injected through it until there is no doubt that it is in the bladder. When the catheter, usually No. 10 or 11 (English scale), is secured in the bladder the operation is over. Usually the inlying catheter is well borne, and is removed in three days, in a very few cases there is irritation set up, and the instrument has to be removed. I always do all I can to persuade the patient to bear with the catheter for at least two days, as I am convinced that by its use the chances of hæmorrhage are much reduced, and the pain and sometimes the difficulty of natural micturition are avoided. The patient sits up about the eighth day, and with the periodical passage of two or three well-warmed, well-oiled steel sounds, the largest usually No. 14 (English) the case is finished. The patient learns to pass these sounds for himself. By this method of mine the patient is not subjected before operation to painful, difficult, and often tedious instrumentation, and he is spared the old plan of dilating up the stricture by tying in a series of small catheters, each larger than the one preceding, which is certainly not the best preparation for a part which it is intended finally to incise, and, above all, the patient is spared a perineal incision with all the slow recovery which necessarily follows such an operation. There is rarely any important hæmorrhage, and there is no risk of the possibility, by no means to be overlooked, of one of the most trying and disagreeable misfortunes, namely, a perineal urinary fistula. I have now an experience of the operation of internal urethrotomy for twenty-seven years, and I am happy to say I have never lost a patient from it. I have only two or three times had any trouble from extravasation of urine, and when this has occurred it has always resulted from an incision in the anterior portion of the urethra, where the extravasation has been

easily and safely dealt with. The avoidance of preliminary instrumentation is important, for it is the disturbance of a difficult stricture by small instruments when the patient is not anaesthetised that is so often followed by urinary fever. The operation at one sitting is usually followed by no constitutional disturbance whatever. Internal urethrotomy is an excellent operation, as I have just suggested, in many cases where there is no real difficulty in traversing the stricture with an instrument. These cases may be grouped as follows under eight heads:—

1. When time is an object. The patient is perhaps ordered on foreign service, or, perhaps, on the eve of marriage, finds that he is the subject of stricture. These instances might easily be multiplied, where it is justifiable to run a little more risk than ordinary dilatation entails in order to get the best and most permanent result possible in the shortest space of time.

2. When the stricture is at the urethral orifice, or in the penile urethra, it will not yield permanently to either continuous or interrupted dilatation, but must be divided.

3. In cases of stricture where the gentlest instrumental interference is followed by rigor and great prostration, if the fibres of the stricture are freely divided, the use of a bougie will cease to be followed by rigor. If after internal urethrotomy, the use of a bougie is still followed by rigor, it will be because the operation has been incomplete, and it must be repeated more thoroughly. Men are often met with from malarious countries who continue to have ageish attacks when resident again at home. I have not infrequently found this fever to be associated with urethral stricture, and have found that the attacks disappear altogether when the stricture is divided.

4. Internal urethrotomy is required when a stricture rapidly recontracts after dilatation. Such strictures are called resilient.

5. Also when the deposit round a stricture is obviously large and dense, dilatation is useless, and the stricture must be cut, and sometimes requires more than one cutting operation before a satisfactory result is obtained.

6. When renal or other calculus is impacted behind a stricture, the stricture had better be divided internally, and, if possible, the calculus extracted *per vias naturales*; should this prove impossible, the calculus may be cut down upon, and the division of the stricture and subsequent treatment will prevent the opening made becoming fistulous.

7. No urethral fistula will ever heal as long as the urethra is contracted in front of the fistulous urethral orifice. Divide the stricture and keep it open by periodical instrumentation, and usually the fistula will close.

8. As age advances it is not unusual, although the contrary has been stated, for a stricture patient's troubles to be complicated by prostatic hypertrophy, making it necessary for him to pass a part, or the whole, of his urine by catheter. To do so he must have a patent and easy urethra; and as stricture tends to tighten up in elderly people many of these patients find increasing difficulty in passing a catheter of reasonable size. Here internal urethrotomy comes to our aid, for the stricture is too hard and inelastic to yield to dilatation.

Much as I dislike incising the perineum there are four conditions where it has to be done.

1. When there is extravasation of urine.
2. When pus requires an exit.
3. In some cases of prostatic calculi, and 4, in certain rare cases of urethral calculus. In the two latter instances, and in one form of prostatic abscess, the urethra must be incised as well. In all cases of periprostatic abscess and of perineal abscess a free perineal incision must be

made at once. The mischief which may result from delay is astonishing. In prostatic abscess I have known pus burrow into the buttocks, and even into the groins, presenting there like a bubo, before incision has been made, and of course the abscess may open into the rectum, causing a rectal urinary fistula, which may need months of careful treatment, and may even embitter the whole of the remaining life time. The ordinary prostatic abscess should be opened from the perineum, but the urethra, in my judgment, should be severely left alone. There is, however, one form of prostatic abscess which I have not seen described, and which needs special treatment. Two forms of prostatic abscess are usually mentioned—the peri-prostatic abscess and the follicular abscess. But I have occasionally been consulted by elderly men exhausted by a profuse and continuous discharge of pus from the urethra, and upon rectal examination have found one or other prostatic lobe simply a bag of pus, draining imperfectly and slowly into the urethra. There has been no periprostatic collection of pus. It is unwise to attempt to go straight into this prostatic bag of pus from the perineum for obvious reasons. I have had great success by opening the urethra behind the bulb from the perineum; I then pass the forefinger of the left hand gently into the prostatic urethra, along this finger I pass a probe-pointed director and, guided by the end of the forefinger, the probe is made to pierce the wall of the prostatic urethra from the urethra. Then a pair of polypus forceps is passed in and opened so as to dilate the wound in the prostatic urethral wall. I have found that, so treated, the abscess drains freely and recovery takes place in cases which under other treatment do not do well.

Then with reference to perineal abscess, a patient afflicted with a tight stricture sometimes, without any very definite cause, finds himself unwell. His perineum is hard, tender, and throbbing, and he may, or may not, have a rigor. We all know that a perineal abscess is in process of formation. All surgeons open such an abscess at once, giving vent usually to a large quantity of matter; in a few days urine is passed by the wound, and, unless the stricture is attended to, a permanent urethral fistula remains; often the stricture is leisurely attended to by dilatation, and even then the fistula is generally obstinate, and a source of annoyance to the patient for years. A real extravasation abscess is not very common; it begins by minute extravasation behind the stricture, but the formation is tedious, and is preceded by a slow growing cord-like process, which is unmistakable to the touch of the practical surgeon. Now my point is this, if the surgeon is prompt in dividing the urethral stricture, a true perineal abscess never will communicate with the urethra, and the patient will be saved all the trouble of a urinary fistula. I freely divide the stricture from inside the urethra, pass a 15 or 16 (Eng.) steel sound, and tie into the bladder a No. 12 gum catheter *per penem*. I then put the patient into the lateral lithotomy position, and, with my left forefinger in the bowel I introduce a sharp narrow knife into the perineum, half an inch above the anus. I go straight in until pus issues, and then withdraw, and in withdrawing divide the skin upwards a little, so that the finger can follow the knife; the finger dilates the opening, and finds a large cavity full of pus, with the urethra filled by the catheter lying above, almost, as it were, dissected away from the surrounding tissues. As a rule this one opening will suffice to drain the abscess, but I have had to make a more dependent opening in the buttock. The catheter should remain in about three days. Patients treated in this way, I find, make easy and rapid recoveries.

In concluding this lecture on the urethra I would submit that while it is very easy to cut into a urethra

it is sometimes very difficult to heal up the incision, and that a urethro-perineal fistula is a lamentable complaint. The urethra should never be opened in any case of vesical calculus, urethral stricture, perineal abscess or extravasation, or for vesical exploration or drainage, or for any prostatic operation. I would look upon urethral incision in these cases as a surgical trespass.

### Clinical Records.

#### NOTES OF A CASE OF A HALFPENNY IMPACTED IN THE OESOPHAGUS.

By DENNIS KENNEDY, F.R.C.S.I.

A CHILD, *et. 6*, was sent to me from Athlone with a history of having swallowed a halfpenny six weeks previously. She was very emaciated, complained of a good deal of pain about the chest, and could not swallow any solid food, but fluids went down freely. I got the child photographed by X-rays, and the photograph showed the halfpenny standing vertically in the oesophagus, opposite the second dorsal vertebra.

On the following day, an anæsthetic was administered, and I extracted the coin through the mouth. I used a forceps with a curve almost at a right angle, after a pattern recently shown by Mr. McArdle. So tightly was the halfpenny impacted that the forceps slipped off of it repeatedly, and I had to dislodge it by a to and fro movement before I could bring it away. The child expectorated a good deal of mucus tinged with blood after the operation, and made an uninterrupted recovery.

### Transactions of Societies.

#### ROYAL ACADEMY OF MEDICINE, IRELAND.

SECTION OF OBSTETRICS.

MEETING HELD FRIDAY, NOV. 22ND, 1901.

The President, Dr. W. J. SMYLY, in the chair.

The following specimens were shown:—

Dr. ALFRED SMITH: Two specimens of fibromyomata.

Dr. JELLETT: Three interesting fibromyomata.

Dr. JELLETT: Uterus and appendages removed for chronic salpingo-oophoritis.

Dr. PUREFOY: (a) Three distinct ovarian tumours removed in one laparotomy; (b) tube containing tubal mole, which lay in front of uterus; (c) ruptured tube and ovum belonging thereto; (d) decidua passed by same patient four days after rupture; (e) ovarian cyst and hydro-salpinx; (f) double hæmatosalpinx.

Dr. WM. SMYLY, on taking the chair, thanked the members of the Obstetrical Section of the Academy for the honour they had conferred on him by twice electing him President of the Section. He remembered the old Obstetrical Society of Dublin, which originated in the Rotunda Hospital, and was the first obstetrical society founded in the United Kingdom.

Dr. JELLETT read a paper entitled

NOTES ON A CASE OF SUPPURATING OVARIAN CYST, COMPLICATED WITH A LARGE INTRA-PERITONEAL ABSCESS.

which will be found in another column. In the discussion that followed,

Dr. MACAN remarked that the woman whose history they had just heard was the worst case he ever had in hospital. He determined on laparotomy on her admission, if anything could be done it should be done quickly. The cause of her condition was found to be a foetid abscess. The fact that for seventeen days after the temperature became normal, that it remained so he considered to be well worthy their thought; it showed how there may be pus without a rise of temperature. He now thinks that he should have drained the abdomen through the vagina, but he found a firm mass in Douglas's pouch, and the patient was not young enough or well enough for a voyage of discovery. The forceps that broke was "made in Germany," but if you take



too weak a forceps, say an intestinal one, to clamp an ovarian pedicle you can break it, even if made in England.

Dr. ALBERT SMITH said one could not estimate the character of the pus from its stench—pus collections in the neighbourhood of the rectum are notoriously bad smelling. The relief of pain felt after opening an abscess, he thought, is due to the diminution of tension of the abscess sac. Emptying the first abscess relieved tension, pain ceased, and temperature fell. Then the second abscess ripened, became tense, and temperature rose. His favourite antiseptic wash was peroxide of hydrogen, with which he washed the sac until the fluid comes back free from air bubbles.

Dr. PUREFOY, Master of the Rotunda Hospital, was of opinion that Dr. Jellett's paper offered several practical points for consideration—there was oozing of blood, which, in such cases, was not without danger. And he could not but think that both the operators, Dr. Jellett and Dr. Macan lacked courage in not opening into Douglas' pouch from the vagina and emptying the pocket of pus which afterwards gave so much trouble, necessitating a second operation. Dr. Jellett's report was not consistent; the mass in Douglas' space is in one place referred to as a hard mass, and again spoken of as a collection of pus.

Dr. MACAN rose to give a personal explanation. Seventeen days after operation if a normal temperature followed by a rise shows that something must have happened.

Dr. JELLETT in reply said, the improvement in the patient after Dr. Macan's operation was only relative. Her temperature fell, her pain ceased for a time; but she could not be got to take food. The mass in Douglas' space had considerably increased between the operations—it was an increase in pus, not a fresh formation. The explanation of Dr. A. Smith of the pain from tension of the sac is probably right.

Dr. HASTINGS TWEEDY read a paper advocating

#### POSTERIOR VAGINAL COELIOTOMY IN GYNÆCOLOGY

as the operation of election rather than that by the anterior fornix. The paper will be found on page 594. In the discussion that followed,

Dr. MACAN remarked that he was old enough to confess he did not know Prior's operation, and was not much enlightened by the paper. Operators had long used both anterior and posterior colpotomy, and Prior did nothing in his opinion except the posterior operation with the use of the Trendelenberg position. He did not think the position in such an operation brings the parts well into view—better without it. Nor could he understand how the ureters or vessels could come into the way of the operator in posterior colpotomy. He looked upon removal of plugs as almost always painful unless you wait for the presence of some moisture, which he recommends, always supposing there is no rise of temperature. In all such cases the question naturally arises, What route will the surgeon pursue: vaginal or abdominal? In unilateral diseases he preferred the superior operation, as one gets a better view of the condition of the parts. In cases of abscess the vaginal route is as a rule the preferable, and when tumour is located in Douglas' pouch posterior colpotomy is to be preferred.

Dr. PUREFOY did not think that posterior colpotomy is so free from all risks as the paper might lead hearers to think. In two recent cases he had had secondary bleeding. One case occasioned him some anxiety as bleeding came on during the night, and he found on his arrival a vessel spouting at the angle of the wounds, on which he had to apply a catch forceps.

Dr. ALBERT SMITH was of opinion that with the use of antiseptics opening the peritoneum has been robbed of its terrors, and he uses the abdominal route in all cases, as giving the best view of the parts, and is no more liable to shock than the vaginal. The painful process of removing plugging might be avoided if a bag were used, and this bag filled with tampons of small plugs, which could be readily removed without causing pain. He had found the early removal of plugs comparatively painless, and had no bad results from doing so.

Dr. JELLETT said the Section had wandered from the subject of Dr. Tweedy's paper, which was a description of Prior's operation. It is obvious, he remarked, that if adhesions were present no tissues fall down, and there is no increased area of view.

Dr. WILLIAM SMYLY could not understand Dr. Jellett's objection. How can we discuss the operation other than by comparing it with the methods of other operators? An operation very similar to this of Prior's is recommended in cases of hysterectomy for cancer. The Trendelenberg position has the great advantage of allowing of plugging the wound. It may be necessary to allow plugs to remain in a long time. As a whole, he prefers the abdominal route, yet he confessed there are occasions when the vaginal is the preferable. Our views are modified by time. We are not now so anxious to excise everything. The tendency is to look at patients years after operation, and on their then condition to decide on the benefits or otherwise of the procedure. Years ago he removed a unilateral pyosalpinx and did it by the abdominal route; he was now able to record that the patient, who went to the country, has been for years quite well, and the mother of a healthy child. In one case he removed the ovaries by the vaginal route, leaving a little of the tubes. Years afterwards the patient had to be again operated on, the remaining portions of the tubes were removed, and the patient is now quite well. Had he selected the abdominal route the second operation would not have been necessary.

Dr. A. TWEEDY thanked them for the friendly criticism his paper had called forth. He brought Prior's operation under notice because it was little known and in certain conditions would be found useful.

The meeting then terminated.

#### LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD NOV. 7TH, 1901.

The President, Mr. EDGAR A. BROWN, in the Chair.

#### THE FINSEN TREATMENT OF LUPUS.

Dr. G. STOPFORD TAYLOR showed a new lamp for the treatment of lupus, diagrams of which have already appeared in the journal. After entering with an explanation of its construction and management, he said that success was only to be obtained by practice.

Dr. LESLIE ROBERTS said that he was using Mr. John Hunter's arc lamp in the treatment of lupus. If the new lamp was theoretically as active as the original Finsen apparatus he thought it would not be long before it would become obsolete. His experience was too recent to speak as to results, but he desired to warn members against being too optimistic. In properly selected cases he had seen the light treatment give wonderful cosmetic results, but the cure was slow and tedious. He thought that we should not rely solely on any one measure in the treatment of lupus. There were many cases in which it would be better to begin with the cautery, and to complete the case with the arc lamp. Time alone could fix the real worth of the lamp treatment.

Dr. GRUNBAUM described Bang's new lamp, which he had seen working in Hamburg. Its chief features were great portability and cheapness. It had cooled iron electrodes, which gave many more ultra violet rays than carbon.

Dr. TAYLOR replied that the idea of metal carbons was impracticable, because the intense heat of the "arc" would convert them into a liquid state. He had not yet met a case of lupus to which he had not been able to apply the lamp satisfactorily.

Mr. R. W. MURRAY related

#### A COMPLICATED CASE OF MALARIAL POISONING.

The patient, a man, æt. 20, contracted malaria two and a-half years ago during a voyage up the Amazon. He was treated in a New York hospital on account of high fever and blood in the urine, and during his stay of ten months in this hospital had the right kidney, the vermiform appendix, and general peritoneal cavity ex-

ploded, and the bladder drained from the perineum. He returned to Liverpool, and remained in good health until August, 1900, when he was admitted to the Northern Hospital suffering from high fever and blood in the urine, from which hospital he was discharged at his own request at the end of five days, although his temperature was 104°. The urine contained a large quantity of blood, and the malarial parasite was present in the blood. He was re-admitted in January, 1901, and has remained in hospital ever since. During this time the temperature has averaged 102°, rarely falling to normal, and occasionally rising to 106°. Repeated examinations of the blood have failed to again reveal the malarial parasite. A cystoscopic examination of the bladder was made, and an ulcer seen close to the right ureter; the bladder was opened and the ulcer treated with nitrate of silver. The hæmaturia then ceased for some time, but returned later and was accompanied by great abdominal pain, referred to the right side, and with violent attacks of vomiting. As the case could not now be considered one of malaria in September, the right kidney was exposed and found to be apparently healthy. During the last month the patient has improved though the temperature remains high, and there is blood in the urine. Numerous drugs, including tannin, arsenic, iron and opium have been tried without any apparent benefit.

Major E. Ross said that the detailed temperature chart was not that of a case in which malaria was the only cause of the fever. The chart showed a continuous fever. He had no doubt that malarial parasites were present, but thought some other cause was producing the long continued elevation of temperature. The blood in the urine was not due to hæmoglobinuria. The spleen was not enlarged.

Mr. D. THELWALL THOMAS showed a patient upon whom he had performed

#### EXTERNAL PHARYNGO-ŒSOPHAGOTOMY FOR TRAUMATIC STRICTURE

in the upper end of the œsophagus, caused by accidentally swallowing fuming nitric acid. Some months after the accident it was impossible to pass bougies. On exposing the stricture by external incision it was found so small as only to admit a fine probe. The cicatricial tissue was divided on a fine probe director. Excision was impossible, and transverse suture not feasible, so suturing was resorted to over an œsophageal tube passed through the mouth, continuous through the mucous membrane, puckering it up over the stricture and Cushing's suture of the muscular coats of the œsophagus. The young man eventually made a good recovery, and now (seven months after operation) can swallow solid food, and a full-sized bougie can be easily passed.

Mr. F. T. PAUL said traumatic strictures of the œsophagus were uncommon, and rarely so favourably situated for operation as in Mr. Thomas's patient. He recognised the difficulties of a plastic operation owing to the fixation of the tube at this point; but evidently enough had been done to render subsequent complete dilatation an easy matter.

Dr. D. M. HUTTON read a paper on

#### MYCOSIS,

dealing with the not uncommon occurrence of mycosis in this country, and the singular paucity of English literature on the subject as compared with that written by Continental authors. Mycosis was defined as the accidental parasitism of dipterous larvæ, i.e., maggots of flies, and was classified according to the distribution of the maggots on the gastro-intestinal tract, the skin, in wounds, and in the nose and ear. Five typical cases of intestinal mycosis were related, two occurring in Dr. Hutton's own practice. Speaking of the aetiology, the opportunities for invasion by the ingestion of the eggs of flies in uncooked vegetables, tainted meat, &c., were dwelt upon, and the wonderful resisting powers of maggots to toxic agents and unfavourable conditions of life generally commented upon. Evidence was given that the eggs or larvæ for the most part perish in the alimentary tract, and that the reason of their survival in the known cases is as yet unsolved. The remainder

of the paper was devoted to the symptoms and treatment of the condition, and with the better known cutaneous mycosis, viz., mycosis vulnerum and narium.

Major E. Ross related some cases of mycosis of wounds which he had seen in India. He thought that the nervous effects so distinctly produced in some of the intestinal cases were instructive in reference to the similar effect of intestinal worms.

Dr. HUBERT ARMSTRONG mentioned a case of intestinal mycosis due to a maggot about one inch in length (name unknown). A purge failed to reveal any further specimens, and there had been practically no symptoms.

Dr. H. JOHN HAY asked if the symptoms produced were due to mechanical irritation or to toxic absorption of poisons produced by the larvæ in the intestine? In helminthiasis definite blood changes have been described, showing that there was probably a toxic agent in addition to the mechanical irritation.

Drs. Kellett, Smith, and Sumner also spoke, and Dr. HUTTON replied.

#### SHEFFIELD MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD Nov. 21st, 1901.

The President, Dr. C. H. WILLEY, in the Chair.

#### CASES.

Dr. GWYNNE showed a girl, æt. 5, suffering from congenital dislocation of the hip, where he had tried bloodless reposition of the head of the femur as recommended by Lorenz. From the difficulty found in retaining the head in the cup of the acetabulum he thought that most probably a portion of the capsule had been included in the reduction. He did not anticipate a successful result from this method, and after a further trial, proposed to open into the capsule and replace the head of the femur by the method adopted with so much success by Lorenz.

Mr. SNELL introduced the following patients:—(1) A young woman, from whom an encapsuled tumour (endothelioma) had been removed from the orbit. The growth reached to the back of the orbit, along the lower floor, and was loosely connected with the eyeball and optic nerve. The globe was preserved and vision was normal. (2) A woman, from whom a sarcoma had been removed from the lower wall of orbit. (3) A man, injured by burn from piece of hot steel. Four rectifying operations had been performed. (a) For ectropion of lower lid; (b) for obliteration of canaliculus (epiphora); (c) for extensive symblepharon; (d) for ingrowing eyelashes of upper eyelid.

Mr. SNELL also showed a large clear cyst (size of a pigeon's egg) removed from the upper and inner angle of orbit. The patient was a young man, æt. 19, and the cyst had existed for many years, but had increased in size, especially recently.

#### HEADACHES DEPENDENT ON EYE CONDITIONS.

Mr. SNELL related a case of headache relieved by correction of refraction error, and remarked upon the effect of cycling in some instances. The patient was a missionary, æt. 32. The headaches were severe, affecting chiefly the left side, upper part, and back of head. They commenced in February, 1899. A doctor declared the eyes were normal, and ordered six months' change of scene, &c., with less work. The patient returned to work, somewhat improved, in the autumn. He managed, though suffering at times considerably, to run on until February of this year, when he completely broke down and was invalided to England. The Medical Board ordered six months' rest. At the expiration of this time he was still unfit for work, and he was recommended to consult an oculist. He accordingly saw Mr. Snell in October last. V=6/6 each eye; after homatropine and cocaine, V=6/6, or +5D cyl., axis horizontal, V=6.5 each eye. Muscle balance was normal. Cylinders were ordered for general use. Relief was speedy and complete. After three weeks he desired to return to work, and on November 23rd took up the duties of a curacy. Mr. Snell remarked on the frequency with which headaches depended on eye conditions, and that knowledge of this relation-

ship was becoming more widely recognised. The instance related was a good illustration of the relief following the correction of error of refraction. The defect was of low degree, as is often the case, but the axis of the astigmatism was contrary to the rule. The muscle balance ought always to be tested. Another point in this case was the increased headache and discomfort which sometimes followed cycling. Mr. Snell alluded to this as occasioned, in this and other instances he had met with, by the rider stooping over the handle bars and thereby necessitating, when looking forwards, the gaze being directed above the horizontal line, thus inducing weariness of the elevator muscles.

Dr. GODFREY CARTER narrated two cases of labour occurring during the course of acute croupous pneumonia. Both patients were multiparæ, and contracted the pneumonia as a sequel of epidemic influenza. Both were *æt.* about 30. The first was a delicate lady (6½ months advanced in pregnancy), and the pneumonia was of a severe type. There was high temperature from the first. On the sixth day, when there was very rapid pulse, great dyspnoea and slight lividity, abortion took place. The child was easily born, and there were no complications. The patient did not seem much worse till the next day. But death ensued forty-eight hours after delivery. The second was a strong, healthy woman. Full-term labour occurred on the second day of the pneumonia. Delivery was easy, but there was an adherent placenta. Chloroform was well borne, but ten minutes was occupied in detaching every portion of the afterbirth, and free hæmorrhage occurred. The crisis of the pneumonia was reached on the eighth day, and a good convalescence ensued. Dr. Carter considered that the hæmorrhage in the second case was probably beneficial by relieving the right side of the heart. He said that labour occurring early during the course of pneumonia, in a healthy subject, and while the powers were still good, was not probably a very dangerous complication; but when it occurred late in the disease it was of grave omen, being, so to speak, a last effort to lighten the ship before going down.

Mr. FAVELL related the following cases:—(1) Removal of unruptured tubal gestation of one side with hydrosalpinx of the other tube; (2) Dermoid tumour of ovary removed by vaginal celiotomy.

Dr. HUSBAND read notes of a case of

HYDATIDIFORM DEGENERATION OF CHORION, and showed specimen.

Mrs. A. C., *æt.* 33. Multipara, having borne one child, four years, and another two years ago, considered herself again pregnant. Menses had stopped one month, and she had bad vomiting and indefinite pains in the lower abdomen. Vaginal examination showed very slight enlargement of uterus, with some tenderness in left fornix. The vomiting was treated with only moderate success for three to four weeks, when hæmorrhage set in which continued for three days. Very soon vomiting returned, and a second vaginal examination was made. Although only twenty-six days since last examination, the uterus was much larger, and of an irregular shape, being bulged out towards the left side, the whole mass about the size of a cricket ball. There was also much tenderness, specially on the left. The os was closed, and there was on examination no hæmorrhage. Vomiting was still severe, and resisted all treatment. Ergot was administered, and was followed in the night by severe hæmorrhage, with some jelly-like discharge and a small cluster of vesicles. The uterus was then emptied by means of fingers and douche. One large cluster attached to a piece of decidua and several smaller clusters of vesicular degeneration were obtained (the specimen as shown). There was slight hæmorrhage, which shortly stopped under hot douche and ergotin, and vomiting entirely ceased. The evening of the same day temperature was 100.5 and pulse 100, the patient enjoyed food, and has so far made a good recovery. The noteworthy points in this case are:—1. That contrary to the usual symptom—hæmorrhage—the chief trouble was the intense vomiting leading to the supposition of hyperemesis gravidarum; 2. The rapid increase

in size of uterus between the first and second examinations, with the irregularity of shape and tenderness; 3. The early period at which evacuation took place. The length of the pregnancy, so far as could be made out, not being more than ten weeks. Most persist to four or more months so far as I have been able to ascertain from recorded cases; 4. The small amount of the vesicular mass, with the amount of decidua membrane, the result of early evacuation. The serotinal part (probably) of the latter was moulded somewhat into a conical shape, and gave attachment to the chief bunch of vesicles. The entire mass measured about half a pint.

## THE GENERAL MEDICAL COUNCIL OF EDUCATION AND REGISTRATION.

Sir WILLIAM TURNER, K.C.B., President, in the Chair.

FIRST DAY—TUESDAY, NOVEMBER 26TH, 1901.

The 72nd Session of the Council was opened on Tuesday, November 26th, with the usual Presidential Address. In dealing with the steps necessitated by the expiration of the tenure of office of two of the direct representatives for England and one for Scotland, the PRESIDENT expressed regret at the cause of Dr. Glover's not presenting himself for re-election, adding that during the fifteen years during which he and Dr. Glover had sat on the Council together he had always received from him unflinching courtesy and consideration.

In reference to the recognition of medical degrees granted by the University of Malta, he stated that the clause in the schedule of University requirements insisting on one year's probationary practice in Malta on the part of foreign graduates had been struck out. An Order in Council, dated September 26th, applies Part II. of the Medical Act to the island of Malta, and two applications for admission to the "Register" from Maltese graduates have already been received.

The information asked for in respect of the requirements of the various Italian universities had been received and referred to the Executive Committee, and five applications for registration had been received from Italian practitioners.

He mentioned that the Bill for the Increase of the Penal and Disciplinary Powers of the Council and of Medical Authorities in the United Kingdom, prepared under the instructions of the Council, had been introduced into the House of Commons by Sir Richard Jebb in June last, and had been read a first time.

The inspection of final examinations at the University of Dublin, at the Royal University of Ireland, and at the conjoint examinations of the three medical and surgical corporations in Scotland had, he said, been completed, and the reports had been forwarded to the respective bodies for their observations and remarks, but the replies had not as yet been received, with the exception of one which only arrived that morning. He raised the question whether it would be necessary for Dr. Herringham, the Council's inspector, to attend the final examinations of the Apothecaries Hall of Dublin next year in view of the fact that all the medical and surgical corporations in Ireland would have their final examinations inspected next year by the general inspector and the Council's visitor.

He referred to the penal cases upon which the Council would be required to adjudicate, most of the practitioners summoned to appear being charged with habitually employing, for the sale of scheduled poisons, persons not qualified to act as chemists or pharmaceutical assistants. He suggested that possibly the time had come for the Council to issue a definite declaration on this subject for the information of the profession generally. One penal case bore on the question of the employment of a registered medical practitioner by a medical aid association, which, it was alleged, systematically practised canvassing for the purpose of procuring patients.

Among other topics he said they might look for a report on the steps which had been taken in order to carry out the recommendation of the Council that the

standard of preliminary examination required by some of the examining authorities should be raised. Certain questions would, he said, come up for debate in connection with motions proposed in June last by Dr. Bruce and Mr. Ball suggesting that, in addition to the examination on the subjects of general education, a second or scientific registration of students should be established by the Council, and that the period of medical study should be four years after the second registration. In discussing this new question he expressed the hope that the Council would bear in mind the paramount importance of their not losing their hold on the standard of general education to be required from students of medicine. He went on to say that the recommendation that all intending students of medicine should pass an examination on subjects of general education, and the consequent establishment of a students' register, formed an important epoch in the history of the Council, and in the educational progress of the profession. Although no special statutory powers had been conferred on the Council to require the registration of students, all the examining authorities were consenting parties, and agreed not to admit candidates for professional examinations unless their names had been previously placed on the students' register. Acting along with the qualifying bodies the Council had been able to require a standard of general education from entrants to our profession, which, in so far as can be provided by an examination test, secured that they possess a school education sufficient to enable them with intelligence to engage in professional study. The period of professional education had also been extended to five years, and an influence for good has been exercised on the training of the younger generation of practitioners. He regarded with apprehension a movement which, by the withdrawal of one or more of the qualifying bodies from an agreement in which all are concurred, would destroy unity of action in the matter of students' registration, and would nullify the influence of the Council.

In conclusion the President announced his intention of placing his resignation in the hands of the Council at the present meeting, so that they might forthwith proceed to the election of his successor.

After the usual vote of thanks to the President for his address, the table showing results of the competitive examination held on August 5th for commissions on the medical staff of the Navy was received, and thanks returned to the department for the same. It was mentioned that there had been no examination for commissions on the medical staff of the Army though one was stated to have been held for the Indian service. As the latter table had not been received the Registrar was directed to write to the India Office to know if the examination had really been held.

#### AMENDMENT OF STANDING ORDERS.

The Council next discussed a report from the Executive Committee in reference to certain amendments in the Standing Orders governing the judicial procedure and decisions of the Council. The President put it to the Council whether the discussion should or should not take place *in camera*, a course against which Mr. Horsley and Mr. G. Brown protested, and on being put to the vote Dr. Athill's motion that it take place *in camera* was negatived.

The President observed that the Penal Cases Committee, which only referred to the Council complaints in which a *prima facie* case had been made out, really acted as a grand jury, and he insisted on the importance of preserving the distinction between the criminal and the professional cases. The first amendment proposed was that Order XIV. 14, (2), (b), should read as follows: "that the facts alleged against . . . in the notice of inquiry have been proved to the satisfaction of the Council," and further, "that further considerations of the facts proved against . . . be adjourned until the next session," or other specified date. This was discussed *in camera* and agreed to.

The Council then adjourned.

SECOND DAY.—WEDNESDAY, NOVEMBER 27TH.

The President, SIR WILLIAM TURNER, in the Chair.

Mr. Muir Mackenzie, the legal assessor to the Council,

was present, and a letter from him was read *in camera*. The Council next proceeded to take into consideration the cases of Alexander Stewart, of Uphall, registered as Lic. Fac. Phys. Surg. Glasg., 1878, M.B., Mast. Surg., 1880, Univ. Glasg.; Simon Prince Clark, of 59, Dixon Avenue, Crosshill, Glasgow, registered as Lic. Soc. Apoth. Lond., 1884, Lic. R. Coll. Phys. Edin., 1885, Lic. Fac. Phys. Surg. Glasg., 1885; Alexander Whyte Mason, of 586, Springburn Road, Glasgow, registered as holding Triple Qualification of Scotland, 1893; William Allison McLachlan, of Dumbarton, registered as M.B., Mast. Surg., 1874, M.D., 1877, Univ. Glasg.; James Wilson, of Dumbarton, registered as Lic. Fac. Phys., Surg. Glasg., 1882; Richard Allan, of Dumbarton, registered as Lic. R. Coll. Phys. Edin., 1872, Lic. Fac. Phys. Surg. Glasg., 1872; and John Steele Smith, of 480, Springburn Road, Glasgow, registered as M.B., Bac. Surg., 1900, Univ. Glasg., who had been severally summoned to appear before the Council to answer the following charge as formulated by the Council's solicitor:—That you have been guilty of infamous conduct in a professional respect, particulars of which are that you, being a registered medical practitioner, habitually employ as assistant for the sale of scheduled poisons a person not qualified to act as a chemist or pharmaceutical assistant, and thereby cause such person to commit breaches of the Pharmacy Act. In the cases of Dr. Clark and Dr. Wilson the charge was that of employing more than one unqualified assistant. The complainants, for whom Mr. Peter Morison, S.S.C., appeared, were the Pharmaceutical Society of Great Britain.

Mr. Winterbotham, solicitor, formulated the charge as given above, and all the gentlemen accused signified their desire to be dealt with together. They were represented collectively by Mr. A. R. Ferguson, solicitor.

Mr. Peter Morison, junior, solicitor, on behalf of the Pharmaceutical Society, dealt with each case *seriatim*, and urged that it was imperative in the interests of the public that the acts complained of should be adequately dealt with. In some of the cases there was an aggravation of the offence, as when, in addition, the name of the person to whom the poison was sold was not duly recorded. He referred to certain statements which had been made that when chemists offended they were not proceeded against and that the present proceedings were vindictive, an allegation which he strongly repudiated.

The President then called on the respondents individually to read the letters which they had sent in reply to the charges made against them.

The letters were then read. The respondents admitted the charge, but among other attenuating circumstances urged that their assistants acted contrary to their express orders and warnings. They concluded by expressing their regret, and pointed out that their offending assistants had been prosecuted.

Mr. FERGUSON, for the accused, denied that he had made a charge of vindictive conduct on the part of that Council, and he protested against the use of such an expression as "infamous conduct" in formulating the charge.

The President said the Council were merely acting in accordance with the Statute. He understood that the charge of vindictive conduct was made against the Council of the Pharmaceutical Society, not against the General Medical Council. He said he understood that all of them, or all but one, were ready to undertake that in future they would not employ or keep unqualified assistants, to which the accused signified their assent.

Mr. MORISON thought Dr. McLachlan had not given the undertaking.

The Council then considered their decision *in camera*, and, when strangers were re-admitted,

The President said: The Council, having carefully deliberated on the evidence contained in the documents before us and the statements which you, gentlemen, have made, they have instructed me to read to you the decision at which they have arrived, and, although I am only going to read it once, yet you must understand that this decision applies to each one of you, and the decision is as follows—that each of you, having expressed to the Council your regret for the commission of a pro-

professional offence, which the Council has declared to be grave and fraught with danger to the public, and having pledged yourselves to abstain from any conduct affording similar ground of complaint in the future, the Council resolve to proceed no further in reference to the facts proved against you.

The Executive Committee brought up a report for the consideration of the Council containing a revised list of scientific institutions at which the course of medical study may be commenced by application for registration in the *Students Register*, and the subject being under consideration when the Council adjourned, further discussion was postponed until the Education Committee's report had been received.

### THIRD DAY.—THURSDAY, NOVEMBER 28TH.

#### A MEDICAL AID ASSOCIATION CASE.

The whole sitting was taken up with the case of Dr. Robert Rendall, of Great Yarmouth, who appeared before the Council to answer a charge "That he had accepted and continued to hold the appointment of medical officer to the Liverpool Victoria Legal Friendly Society, a society which systematically practised canvassing for the purpose of procuring patients, and that he had approved of, or acquiesced in, such canvassing."

The case was brought before the Council by the Medical Defence Union, as complainants, on behalf of the Great Yarmouth District Committee of the Incorporated Medical Practitioners Association. The respondent was represented by Mr. Lawson Walton, K.C., M.P., and Mr. C. Mathews.

Dr. BATEMAN, in laying the case before the Council, pointed out that it raised a question of the greatest importance not only to the profession but to the public. He referred to the resolution of the Council passed in June, 1899, strongly disapproving of medical men associating themselves with medical aid associations which systematically practised canvassing and advertising for the purpose of securing patients. The society existed for the purpose of providing medical advice for persons then in good health, who paid a small entrance fee, and members were canvassed for by agents from door to door quite irrespective of their ability to pay for medical attendance or whether they had medical advisers of their own. This had led to much friction between the society and the profession. He pointed out that it might be said that Dr. Rendall himself did not canvass, but it would be shown that the people canvassed were asked to join the doctors' club, and Dr. Rendall's name was systematically mentioned by the canvassers.

Mr. W. E. Wyllys, of Yarmouth, was the first witness, and he described the mode in which the canvassers went to work, in support of which he produced a number of documents. He admitted that Dr. Rendall had written to him asking for the names of the persons whom it was alleged he had canvassed, a request with which he had not thought fit to comply, the facts being common knowledge. Similar evidence was given by Mr. A. H. Moxon.

Dr. BATEMAN put in a large number of statutory declarations of local medical men and persons who had been canvassed. To the latter had been handed burial cards and also Dr. Rendall's cards.

Mr. LAWSON WALTON, speaking on behalf of Dr. Rendall, pointed out that the Council had to consider two distinct questions, (1) whether the allegations against Dr. Rendall, if proved, would bring him within the scope of the June resolution, and (2) whether upon the facts it could reasonably be held that there had been professional misconduct. He urged that, as it could not be intended to proscribe the numerous small societies which catered to the medical wants of the very poor who would not have a medical man of their own, therefore the allegation of canvassing to procure patients could not be held to apply to these. He denied that there had been any systematic canvassing by the medical aid society of which Dr. Rendall was the medical officer, whatever canvassing there was having been to promote the insurance business and not to procure patients. He mentioned that only 150,000 of the twenty-two and a half million members of friendly societies availed

themselves of the medical aid society. The managers of the society, and the men themselves, denied having canvassed for the medical society, and he said he should produce statements contradicting the specific allegations made in the statutory declarations, and he should call Dr. Rendall and the principal officials to prove what their attitude had been. In conclusion, he pointed out that upwards of 2,000 medical men connected with similar societies would be affected by the decision arrived at.

After further evidence had been given by managers of the Liverpool and Medical Aid Societies tending to refute the allegations of systematic canvassing for the latter—

Dr. Rendall was called forward once more. Questions by his counsel he said he saw many persons connected both with the Friendly Society and the Medical Aid Society. They were very poor. They could not afford medical assistance, he thought, except in this way. When complaint was made, he made inquiries, and so far as he could find out, there was no canvassing. He asked his patients how they came to know of the Medical Aid Society and they said through their friends. He had no idea that canvassing was being carried on for the Medical Aid Society. He had not canvassed nor had he been a party to canvassing for patients. In cross-examination, he denied all knowledge about the cards which had been produced, and could not explain how they had reached the persons.

The further consideration of the case was postponed until the following day.

### FOURTH DAY.—FRIDAY, NOVEMBER 29TH.

The first item on the programme was the consideration of the case of a dentist who was found guilty last session of having unjustifiably made use of letters after his name, calculated to convey the impression that he was a licentiate in dental surgery of the Royal College of Surgeons of England, which was not the case, he having been registered in virtue of having been in practice before 1878. As he stated that he had erred in ignorance, and promised to sin no more in this particular way, he was let off with a caution.

#### ITALIAN MEDICAL DEGREES.

The report of the Executive Committee bearing on the value of Italian qualifications was brought up. They had satisfied themselves that the regulations of the Italian Universities provide a sufficient standard of professional knowledge, consequently the degrees in medicine and surgery of such Universities are recommended for admission to registration in this country, applicants to be required to afford suitable evidence of identity, &c. A motion to refer the report back to the committee having been negatived the report was received and adopted.

#### REPORT OF EDUCATION COMMITTEE.

Some desultory discussion took place on a very elaborate report prepared by the Education Committee on the steps taken with the object of securing improvement in the standard of preliminary examinations.

Sir JOHN BATTY TUKE, in introducing the report, said that the oldest of their Universities had met the committee on common ground in working for the common good, and he hoped that the Government would shortly bring in an adequate Education Bill.

Dr. NORMAN MOORE criticised the wording in respect of the matriculation examination of the University of London and suggested an alteration. Ultimately the discussion was adjourned.

#### THE MEDICAL AID ASSOCIATION CASE.

The consideration of the case of Dr. Rendall was then resumed. Some discussion took place on the question of the confirmation of the minutes, and then Dr. Rendall was recalled. In reply to his counsel, he said that, as far as he had ascertained, there were no canvassers for the Medical Aid Society, and he said the statements made as to his having personally canvassed were untrue. A collector for the friendly society was called, and stated that he had received instructions on no account to canvass

for the Medical Aid Society, and he added that the statements made concerning him were deliberate falsehoods. A second canvasser gave evidence to the same effect. After some further corroborative evidence had been given, Mr. Lawson Walton, having been authorised by the Council to make any further remarks, urged that the charge had not been established and that the evidence based on the statutory declarations was absolutely untrustworthy. Alluding to the suggestion that all difficulties would be avoided if there were a separation in the staff of the Liverpool Society and the Medical Aid Society, he said it would not be worth the while of the Medical Aid Society to organise a staff of its own, and that it would be better to let it die.

Dr. BATEMAN, in conclusion, contended that the charge had been proved up to the hilt; the canvassers went not only into the houses of the poor, but also to the residences of the well-to-do, so that it could not be said that the institution was for the benefit of the poor. He added that what was objected to was the canvassing and that alone.

The Council then deliberated for a long time *in camera*, and on strangers being readmitted the PRESIDENT, addressing himself to Dr. Rendall, stated that the Council regarded the charges as satisfactorily proved. He insisted on the gravity of the offence of which he (Dr. Rendall) had been found guilty, and said that in order to give him an opportunity to reconsider his position the further consideration of the case had been adjourned until the next session. The Council then adjourned.

#### FIFTH DAY.—SATURDAY, NOVEMBER 30TH.

Sir W. TURNER, President, in the chair.

#### A QUESTION OF PRIVILEGE.

The PRESIDENT said his attention had been called to a letter in which his action in the chair had been challenged, and it was practically alleged that he had acted in a way that he should not have done. This, he observed, was a matter of importance, as affecting three persons—namely, the member of the Council who is alleged to have made the statement, the President, and another member of the Council, regarding whom it is alleged the President had acted in a way that he should not have acted. That must be regarded as a question of privilege. It affected several members of the Council, and what he proposed was that the letter should go on the programme of business for Monday. Members of the Council would then have the opportunity of seeing what had been stated, and also an opportunity would be given to himself to formulate an answer.

#### REPORT OF EDUCATION COMMITTEE.

The Council then resumed the consideration of the second report of the Education Committee on the steps taken for the improvement of preliminary examinations.

Dr. MOORE, referring to the amendment suggested by him on the previous day, said that his proposal would remove a practical difficulty, but under the circumstances he would withdraw his amendment.

On the original motion, Professor WINDLE contended that it was quite impossible for the Council or any other body to suddenly raise the standard of preliminary examinations without producing a dangerous dislocation in the educational affairs of the country. He believed such action would have a dangerously depressing effect on the number of medical students entering the profession.

Sir C. NIXON said if the Council was not prepared to deal with these matters in a uniform way he should be obliged to advise those whom he could influence that it was not absolutely necessary to assent to or follow the Council's recommendations. He strongly protested against distinctions being made, reminding his colleagues that they in Ireland had charters as long as any in England.

Mr. BRYANT expressed his surprise at its being said that some of them were trying to go against the wishes of the Council. They were loyal to the Council, and should continue to be so in the future unless the Council gave them some good reason for their acting otherwise.

Dr. NORMAN MOORE declined to be led into discussing the question of the length of charters on this or the other side of the Channel, or the question whether William III. or Henry VIII., who lived a little earlier, had done more mischief to the human race.

Dr. PETTIGREW hoped they should not have, as he feared they might have, one law for England and another for Ireland in this matter.

Dr. GLOVER thought a great responsibility rested on the Royal College of Surgeons in Ireland, whose representative had introduced a subject which led to so much debate. He believed if they were to go to the Privy Council to adjudicate between the Council and the Colleges they would come to grief.

Sir J. B. TUKE having replied, the closure was moved and carried unanimously, and the report, of which high approval generally had been expressed, was adopted.

#### REPORT OF PERSONATION COMMITTEE.

Mr. HORSLEY then brought up the report of the Personation Committee. The report set out with much minuteness provisional regulations to guard against personation abuses, some of which were very gross indeed, instances have been mentioned in which a "coach" had passed an examination personating his pupil. The regulations applied to practitioners as well as to students. The report was under discussion when the Council adjourned.

## Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, Nov. 30th, 1901.

THE *Deutsch. Med. Woch.*, 30/01, has an article on the TREATMENT OF DYSENTERY

by Dr. Plehn. Whenever dysentery is diagnosed or even suspected, the patient has two tablespoonfuls of castor oil given. Examination of the following stools clear the diagnosis in doubtful cases, and allows an opinion to be formed as to the extent and degree of the intestinal changes that have taken place. But above all the laxative removes a large quantity of infectious material from the canal. When the immediate action of the oil has subsided the calomel treatment is begun. A tablet containing 0.03 grn. is given every hour until twelve have been taken. The course is repeated the next few days, none being given during the night. It is important that the calomel be given in the tablet or tabloid form, as no particles of the calomel are then liable to be left in the mouth and setting up stomatitis. Moreover, the patient must wash out his mouth with great care every time he has taken his tablet with a solution of tincture of rhubarb in water, or with a solution of salicylic acid. If any suspicion of stomatitis arise the gums must be scrubbed with a mop of cotton soaked in one of the solutions named. An interruption of the calomel treatment is not necessary, but it is necessary to continue the care and treatment of the mouth for at least three days after stopping the calomel. After the calomel tablets have been given for three days, twelve tablets of bismuth subnitrate of 0.5 grn. each should be given hourly, the mouth being looked after and treated for three or four days. Six grammes of bismuth per day are given until the stools are formed, and until nothing pathological has appeared in the stools for some days. Then the patient takes three grammes per day in doses of half a gramme. With tendency to constipations in the later stages or with post-dysenteric intestinal catarrh a quarter to half a litre of artificial Carlsbad water is given. This may be taken for some weeks with the best results after the

drug treatment has been finished with. If irritability of the mucous membrane of the intestinal canal continues, Kissingen water may be given instead. The diet is of prime importance; a milk diet is impracticable. During the first few weeks, and until the stools are reduced to one or two a day, and until they are distinctly formed, a mixed, but exclusively liquid diet is given, the basis of which is rice cooked and strained, bouillon, eggs beaten up, gruel, cocoa, and, as far as possible, milk. A good Bordeaux is also given. When the stools have become free from mucus and traces of blood for some days, and when patients have often acquired a sharp appetite, an addition may be made of mashed potato, porridge, egg, with a light biscuit and perhaps a fruit jelly, Tropon may also be given, best with water as a medicine, and in it two tablespoonfuls mixed with water to a thick consistence and eaten with a spoon without any addition. Only twelve to sixteen days after all symptoms have disappeared should meat be given, and then that of the lightest with vegetables. A commencement should be made with scraped ham and minced fowl, and later on the more usual kinds.

#### THE QUININE TREATMENT OF TYPHOID FEVER.

Professor Goldscheider has some observations on this in the *Therap. d. Gegenwart*, 7, '01. In the high continued fever the effect is unsatisfactory in the majority of cases, especially in the first half of the stage. In the very early days, and in the latter half, on the other hand, the effect is better. If a dose of quinine acts only on the duration of the exacerbation, it is advisable to give another dose twenty-four hours later—perhaps a larger dose; but if the evening temperature is materially influenced it is well to pause for a day as the effects become less. In the *continua continens* large doses must always be given 1.5 to 2 grns. Its action may throw light on a doubtful case. Its efficacy in short-lasting continued at a time when it cannot be distinguished from a severe case is a favourable prognostic, whilst a maximum effect in medium length of curve not unfrequently indicate severe infection. A good effect may indeed be seen in cases that end fatally, but the fatal result is often due to complications and not to the fever itself. In regard to the question whether a morning or evening dose is better, the author has arrived at the conclusion that the evening administration is the more rational. Generally speaking, it is best to give the quinine about eight o'clock in the evening.

### Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, Nov. 30th, 1901.

#### SURGERY OF STOMACH.

At the Gesellschaft der Aerzte Uilmann showed a patient, æt. 44, who became ill seven years ago with loss of appetite, general malaise, and vomiting. On two occasions the vomit was bloody, while the stools were also much blood-stained. The diagnosis at the time was ulcer of stomach. In November, 1900, an elongated growth began to show itself in the left hypogastric region, very painful on pressure, while vomiting was severe. From these signs it was concluded that this was either carcinoma or perigastritis ulcerosa.

Operation revealed a large round ulcer which had

become attached to the wall of the abdomen, through which it had almost penetrated.

The second case had a similar history, which after operating was found to be an hour-glass stomach with a hard cicatrix at the stricture, through which the finger had difficulty to pass. The origin had been a deep ulcer of the stomach. Gastrostomy was performed with the best results, and both patients perfectly recovered.

#### WRITERS' AND PIANISTS' CRAMP.

At the "Doctoren Collegium" Bum propounded the pathology and rational therapy of writers' cramp as well as to that of pianists', who were most frequently attacked with this malady, although others who were confined to protracted restraint were also subject to the disease. Happily, this co-ordinative professional neurosis was not so common as might be expected. The very rarity of the disease has created a sort of scepticism in the profession that has not infrequently driven the patient to take refuge in the counsel of charlatans chirographers, &c. After analysing the graphospasm, its stages, and varieties, which depend largely on the constitutional vigour, Bum considered the disease parallel with the theories of Erb and Benedikt in their demonstration of neuropathology. All these professional defects may be relegated to the *circulus vitiosus*, which primarily commences with a disturbance in the peripheral nerves through muscle or nerve exhaustion which soon affects the co-ordination centre, culminating in loss of energy, inanition, and loss of power in large groups of muscles. The ætiology or more remote origin may often be traced to alcohol, over-exertion, false technique, unsuitable writing materials and table, or it may be due to the uratic diathesis, or injury.

Zabludowski has shown that traumatic arthritis, through compressed or constricted playing of the piano, in young children are often the initial point that act on the centripetal nerves, resulting, as Bucheim has ably demonstrated, in a neurosis of the peripheral nerves also. Probably the exhaustion in this complicated exercise may set up a functional disturbance that may lead to the same result.

The first part of the treatment must be total abstinence from everything that has induced the cramps, viz., playing, writing, or working. Locally, warm bathing, massage, passive movement, and some other gymnastic exercise. Various devices and apparatus are before the public to facilitate writing which may be taken advantage of when entire abstinence cannot be submitted to; this partial treatment is never satisfactory.

Of all the forms of this cramp the spasmodic is the most amenable to treatment. Bum said he had had thirty-five cases (writers) of this class: eighteen were cured or improved; seventeen pianists, of whom eleven were cured. These are exclusive of violinists, dancers, cyclists, masseurs, tennis players, &c., &c.

#### NEW NARCOTISING APPARATUS.

Braun showed an instrument for giving chloroform in combination with ether, or singly, simply by turning a tap on the instrument for ether or chloroform or both at the same time.

PROFESSOR W. J. SIMPSON has been appointed, as an expert on plague, to advise the Government of Hong Kong as to the means to be adopted to check the continued prevalence of the disease.

## Hungary.

[FROM OUR OWN CORRESPONDENT.]

BUDAPEST, Nov. 30th, 1901.

At the recent meeting of the Royal Hungarian Medical Society, Professor Elischer, of Budapest, read a paper on

### THE EMPLOYMENT OF HEROIN IN GYNECOLOGY.

According to the statistics of the last three years, 375 patients out of 10,101 (3.87 per cent.), in the out-patient department, suffered from carcinoma. Among these only 105 (11 per cent.) were considered suitable for operation of any kind, and in only seventeen cases was total removal indicated. The other patients, who wander from one hospital to another, consult the surgeon chiefly in order to obtain alleviation of their painful symptoms.

The pain associated with cancerous affections of the womb soon defies the drugs in general use, and, therefore, I decided to administer heroinum hydrochlorium recommended by Dreser, Gerhardt, and others.

Compresses soaked in a 1 per cent. glycerine solution of heroin were used in twenty hospital cases. In half the cases the pain was due to peritoneal irritation; in the other half to inoperable uterine cancer.

In cases of ascending gonorrhoeal perimetritis, as well as in cases of diseases of the adnexa, I succeeded in diminishing the pain. In one case of inoperable cancer I obtained a remarkably satisfactory result. Heroin proved useless in cases in which the cancerous degeneration involved the pelvic connective tissue and the glands.

In cases of nervous restlessness and sleeplessness, and in hysterical women the administration of heroin gave little or no relief.

Professor Havas exhibited a case of

**EXANTHEMA UNIVERSALE TUBEROSUM ET PLANUM**, of seven years' standing, in a girl, *æt.* 8. He had shown the girl four years ago, and his object now is to demonstrate the subsequent course. The disease started originally in the skin of the forehead. As to the treatment, he said that in all such cases the only radical cure is the operative excision of the xanthoma, but this can be performed only in cases in which the affection is not universal, as in the present case. Electrolysis is sometimes followed by satisfactory recovery, even in certain cases where one would hardly expect it. Its only disadvantage is that recurrence of the xanthoma is common after its use. The patients exhibited by him in whom by reason of the generalised nature of the affection neither of the above-mentioned methods was applicable, is taking phosphorus and turpentine internally, as recommended by Besnier.

Dr. Hudovering read a paper on the

### TABES OF MARRIED COUPLES.

Up to the present twenty-seven cases of tabes conjugal is recorded in the literature of the subject, Hudovering now placed on record three further cases of the kind. It must be premised that in all the three couples the tabes was subsequent to syphilis, a relationship which existed in the recorded cases, in fact in twenty couples out of twenty-four, syphilitic infection was distinguished with certainty, in three couples there was reason to suspect it, and only one couple proved to be really free from syphilis. It

follows that in 96.3 per cent. of the conjugal tabes cases there was antecedent syphilitic infection. The theory first brought forward by Lougres that tabes and general paralysis are produced by a special form of syphilis, *i.e.*, a *virus nervosum*, which, in his view, possesses a special affinity for the central nervous system, Hudovering declined to accept this view until placed in possession of real proofs. He holds, therefore, that the reason why so many syphilitics develop tabes or general paralysis while the remainder are free from any sequelæ of the kind, is not to be sought in the above-named affinity of the syphilitic virus for the central nervous system, but that this special predisposition is to be sought for in another direction, perhaps in the congenital or acquired particular disposition of the nervous system.

## The Operating Theatres.

### TOTTENHAM HOSPITAL.

**OPERATION FOR EXTRA-UTERINE PREGNANCY.**—Dr. ARTHUR GILES operated on a woman, *æt.* 34, who had suffered first for two months from amenorrhœa, this being followed a fortnight later by a second more serious period. There had been considerable hæmorrhagic dribbling, followed by pain in the right side, which gradually increased. On admission she was very collapsed. A diagnosis of extra-uterine pregnancy having been arrived at, operation was performed the following morning after the patient's admission. A tumour was found the size of the fist, which was removed, together with the right appendages; an unruptured tubal gestation being found in the proximal half of the right tube. The mass was very closely adherent to the right corner of the uterus, and it involved half the tube, the remaining half being almost unaltered. Owing to the patient having lost so much blood previous to operation and to admission, transfusion of normal saline solution was done before the woman was removed from the table at the end of the operation. On cutting open the specimen a fœtus of about seven or eight weeks was found in a small amniotic cavity which projected so far on the surface as to give the impression that rupture was imminent. Dr. Giles said that the points of comment in this case were: (1) the importance of collapse as a means of diagnosis in conjunction with pain and slight hæmorrhage; (2) the relative rarity of these proximal pregnancies without rupture; (3) the value of transfusion as a restorative measure without waiting for very serious symptoms at the end of the operation.

The patient made an uninterrupted recovery.

### A Sale of Practice Action.

In an action tried in the King's Bench Division last week Mr. F. B. Thompson, of Maida Vale, claimed damages from Mr. D. H. Beegling for alleged misrepresentation in regard to the sale of a practice which, according to the books, brought in between £400 and £600 a year to the vendor and nothing at all to the purchaser. The vendor had himself purchased the practice in 1897 for £620. There was the usual conflict of evidence, one question being whether the Maida Vale practice alone was sold or whether it included that part of Mr. Beegley's practice in West-End hotels. Ultimately the jury was discharged without having agreed upon a verdict.



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**The Medical Press and Circular.**

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, DECEMBER 4, 1901.

**THE GENERAL MEDICAL COUNCIL.**

THE session which was inaugurated last week, though it has not witnessed any very exciting debate of the kind to which we have of late years become accustomed, will be remembered for several reasons. In the first place, it witnessed the first practical application of the principle of reciprocity of medical practice. The Executive Committee, having satisfied themselves that the regulations and requirements of the Italian Universities provided an adequate standard of professional knowledge have recommended the Council to admit Italian graduates to registration in this country on satisfactory evidence of identity, &c. Similar reciprocity will in future be extended to graduates of the University of Malta though, as this is a British possession, the concession is not quite on the same footing. Thus is inaugurated a new era, and protectionism has been ousted from one of its least defensible strongholds. It may be anticipated that in the near future this principle will undergo considerable development, a development which must be jealously watched in order that it shall only establish equality *inter paria*.

The prosecution of a batch of "open surgery" practitioners in Scotland will, no doubt, bring home to those who are still in the position of violating the law regulating the sale of poisons the propriety of mending their ways. The principle having thus been formally established, future offenders cannot reckon on receiving the indulgent treatment which has been extended to these, the pioneers. If the difficulties which this pronouncement will introduce into the carrying on of a retail drug trade by registered practitioners should have for effect to discourage this conjunction of trade with the practice of medicine the profession will be the gainers. The most important event of the session is probably the consideration of the case of Dr. Rendall, of Great Yarmouth, who was charged with being asso-

ciated with a medical aid society which systematically canvassed and touted for patients. The case was gone into at great length, and the respondent had the assistance of eminent counsel, but the evidence was overwhelming, and the ingenuity of the defence was mainly directed to the discovery of technical loopholes, a device which might conceivably have proved successful in a court of law, but invariably falls short of its object before the Council, where the rules of evidence are somewhat more elastic. It was stated that upwards of two thousand practitioners await with interest, possibly with anxiety, the decision of the Council, a number which shows how widespread the system has become. It was pointed out that the difficulty would disappear if the administration of the friendly society were separated from that of the medical aid society, but respondent's counsel said he had been informed that this would not be practicable, and that they would probably prefer to let the medical aid society die out. That, perhaps, is the best thing that can happen, although it was by no means the object aimed at, which was merely to prevent a society doing for a practitioner what that practitioner would not dare to do for himself. After a most patient hearing the Council arrived at the conclusion that the charges had been proved, and as this was a test case they postponed the further consideration of the matter in order that Dr. Rendall may put his house in order before the next session, when he will have to appear and prove that he has taken the lesson to heart.

**AN OBJECT-LESSON IN VACCINATION.**

THERE are obvious objections to the publication of statistics in the course of a prevailing epidemic, but, since the errors are known beforehand and can be allowed for, the advantages attending a clear statement of results as far as they go far outweigh the drawbacks. We welcome, therefore, the publication in the *Times* for last Saturday of the salient features of the returns of the present epidemic of small-pox in the metropolis. The number of cases, it is true, is rather small for statistical purposes, and as the fatal cases are always in advance of the recoveries, the mortality at any given period must necessarily appear higher than it really is. Although it is necessary to point this out in order to avoid misconception, the error applies all round and does not invalidate a comparison between different classes of cases. The first point to attract attention is the very wide distribution of the epidemic, no part of London having escaped. Cases have occurred in many districts which rejoice in an unholy notoriety for dirt and overcrowding, yet by far the greater number of cases occurred in the district of St. Pancras, a district which is less poor and overcrowded than several others. The only light, says the writer of the article, which the returns throw upon the question is the fact that the proportions of deaths and unvaccinated from St. Pancras were both excessive. Of 349 patients, 181 were males and 168 females. The age

of maximum amenability to infection seems to be between twenty and thirty, and after fifty the liability to small-pox appears to be slight, though when persons over forty do contract the disease the rate of mortality is extremely high. Of the 349 cases 116 ended fatally, representing an apparent case mortality of 33 per cent., an estimate which, as we have already explained, is in excess of the truth. The author divides the cases into three groups, vaccinated, unvaccinated, and "doubtful," and it is hardly necessary to point out that "doubtful" is almost an exchangeable term for unvaccinated. The vaccinated cases numbered 233, and showed a mortality of 20 per cent. The mortality among the unvaccinated and doubtful was 60 and 57 per cent. respectively, so that the rate of mortality among the unvaccinated was thrice as great as among the vaccinated. When all the non-fatal cases belonging to the same period are added the rates will, of course, be lowered, but the difference of mortality between the vaccinated and the unvaccinated will probably be increased because the great majority of the favourable cases are among the vaccinated. Analysing the figures, we find that all the cases of small-pox under five years of age were unvaccinated, and of these nineteen out of twenty-three died. Under ten all were unvaccinated except one, and of forty-two there were twenty-nine deaths, all among the unvaccinated. Out of a total of eighty-one children under fifteen, fifty-seven were unvaccinated, and of these thirty-eight died, while of twenty-four vaccinated children twenty-three recovered. The figures show that the protective influence of vaccination diminishes progressively after childhood, but at every age the unvaccinated cases show a vastly higher mortality than the vaccinated. Two deaths occurred among revaccinated persons, revaccination having been performed, in one six, and in the other seven, years ago. It is a significant fact that no instance has occurred of the occurrence of small-pox among the immense numbers of those who have recently been revaccinated at a time when they may be assumed to have been free from infection. With regard to the relative severity of the attacks it is mentioned that the confluent and hæmorrhagic forms occurred in 22 per cent. of the vaccinated and in 73 per cent. of the unvaccinated, and, as in all other epidemics, the measure of protection appeared to be in direct proportion to the number and area of the scars. We welcome this brief synopsis because it comes opportunely as a set-off to the wearisome juggling with figures with which the Press has of late been inundated. The figures afford irrefragable proof of the protective value of vaccination, a protection which, though it be not as permanent and as absolute as was at one time hoped, is nevertheless striking enough to convince the most sceptical. We note in this connection that at a recent meeting of the Association of Public Vaccinators a resolution was passed in favour of transferring the whole administration of vaccination from the control of local bodies to the Local Government Board, or some other central body. In view of

the obstructive tactics of many boards of guardians at the present time this expression of opinion deserves serious consideration.

#### THE PURSUIT OF HEALTH.

THE pursuit of health is with some persons almost as absorbing a task as the pursuit of pleasure by others. In both cases the intellectual phase is capable of much philosophic sifting whether considered in the purely individual aspect or on the wider basis when the attention of a community is involved. There can be no doubt that in many instances the search for health is simply a valetudinarian expression of lack of proper mental and bodily occupation, but the hypochondriac may be found in all ranks of society, from the duchess who fosters bone-setters and quack medicines, to the club patient or the workhouse inmate who swallow physic literally by the hogshead in the course of the year? As to the average working man, it may be said that he has no time to be ill, and if he sicken and fall out of the ranks the only course open to him is to die. In fulfilling that destiny he is simply obeying the remorseless laws of the struggle for existence by which Nature has ordained that man shall work out the salvation of his race. Some day it is not improbable that the more equal distribution of property which is likely to take place in a far future will result in the health of the producers being carefully guarded by the State. Meanwhile the progress of civilisation has been mainly in the direction of the fostering of weakly individuals by enabling them to hold property in safety. The wealthy invalid is able to secure for himself every possible condition of environment favourable to the prolongation of life and the arrest or cure of his complaint. The sick man who is not wealthy, moreover, commands a vast deal of attention under latter day social organisations. The great modern system of medical service, both State supported and voluntary is to a great extent directly concerned in bolstering up the weak and the sick and those defective in mind and body, who would perish if left to their own resources. In this way the humanity of mankind thwarts in practice the precepts that have long ago been framed by philosophers with a view to the construction of ideal Utopias from which the unfit shall have been ruthlessly exterminated. Philosophers, however, have always to reckon with the emotional side of human nature in their endeavour to govern mankind by the force of pure reason. The existence of that moral protest, for instance, negatives for once and for all time the proposal to encourage marriages on grounds of artificial selection so as to breed a race of men on lines that have been reduced to a science by cattle breeders. While humanity is humane its methods are not likely to alter much in principle. The care of the sick in civilised communities is certain to continue a prime object of solicitude, although signs are not wanting that some day the State may assume the burden that has hitherto been borne mainly by the shoulders

of the philanthropic citizen. The endless pursuit of health, whether by the hypochondriac or by the weak, is in some way or other a standing reproach to our imperfect condition of development. In some cases the environment of the individual is at fault, and he is the mentally enfeebled product of a defective system of up-bringing which has failed in his physical or his intellectual education, and has turned him out into the world with no definite object in life. In other instances he has been the victim of insanitary surrounding in home or in factory, or of preventible disease in one of its myriad forms. It is with these two last mentioned factors that scientific medicine is concerned, and may be said to be itself engaged hotly in the pursuit of health. Preventive medicine by reducing the incidence of some infectious diseases and by exterminating others, has achieved and is achieving prizes of incalculable value in this absorbing chase. Thanks to the medical profession, plague and cholera have been banished from the shores of the United Kingdom, typhus fever and small pox have received their death blow, and various other deadly infectious diseases show signs of the defeat that sooner or later awaits them in the warfare that is being waged against them by modern sanitary science. In spite of the fields that have been won, however, much is left to be conquered. A great unknown wilderness remains to be explored before medicine can be reduced to the position of an exact science. That *terra incognita* is the happy hunting ground of the quacks who prey on unwary persons wandering thitherwards in the pursuit of health. It is to be hoped that the attainment of the day of fuller knowledge will enable legitimate medical practitioners to rescue all who are in search of health from the clutches of the patent medicine vendor and the charlatan.

### Notes on Current Topics.

#### The Resignation of Sir William Turner.

THE announcement made by Sir William Turner, the President of the General Medical Council, at the close of the address with which he opened the recent session of that body, in reference to his intention to place his resignation in their hands, comes upon us as a surprise. Since Sir William took up the sceptre which had fallen from the hands of the late Sir Richard Quain, he has proved in many respects an admirable president, whose rulings have almost always been deferred to with respect. His long experience of Council business and his own decision of character enabled him to control the debates and to guide them to practical conclusions. Certain incidents, to which we need not now refer, showed that he was not altogether in touch with the new spirit which has been imported into medical politics, and on more than one occasion he went out of his way to place obstacles in the path of those who recognised the imperative necessity of reform in certain departments of the

administrative work of the Council. *Errare humanum est*, a failing from which even the most distinguished are not exempt. The Council will remember Sir William as a conscientious, hard-working president, as a man of sound judgment and good counsel, who endeavoured, generally with success, to be impartial. Those who know the amount of labour and the responsibility which appertain to the post of president of Council will readily understand and sympathise with Sir William's desire to be relieved of the burden. His services to the medical profession in many important capacities over a very long period of years entitle him to a well-earned repose which, we trust, he may long live to enjoy.

#### Medical Advice in the Lay Press.

FOR many years it has been the custom of certain lay papers to give medical advice in their columns. In one well-known Sunday paper several columns are given by a "physician whose qualifications for the work are of the highest." This person is, of course, anonymous, or the Medical Council would promptly take cognizance of his existence, if, indeed, he be a medical man at all. Not long since, however, an advertisement appeared in a daily paper for a medical man to undertake the medical columns of a weekly journal, presumably the journal in question. For any medical man to prescribe for hundreds of patients he has never seen on the sole evidence of their necessarily imperfect description of their own symptoms is not only absurd but constitutes a positive danger to the public, to say nothing of a disgrace to the practice of medicine. It is a pity that a paper edited by a brilliant journalist should descend to commerce of this kind. Even worse than this are the advertisements of so-called skin specialists and others who mostly have rooms in Bond Street. These people advertise in the periodicals which appeal mainly to lady readers. We read that Madame X. will remove superfluous hairs and perform many other operations which are the province of the dermatologist. That such people should be allowed to carry on these practices with impunity is regrettable, but the Medical Council have apparently no power to stop it. It is possible that some of these advertisements are merely a cover for places of assignation or worse, as in the case of the notorious "massage" establishments.

#### The First American Practitioner.

AMONG "the names of those which came over first, in ye year 1620, and were by the blessing of God the first beginners and (in a sort) the foundation of all the Plantations and Colonies in New England; and their families," we read the name of "Mr. Samuel Fuller, and a servant caled William Butten." According to Dr. Packard, who has recently published a work entitled "A History of Medicine in the United States," there is little doubt that the earliest practitioner of medicine in Massachusetts was Samuel Fuller, who was among the passengers on

the 'Mayflower' in 1620. Apparently Fuller held no diploma or official recognition, but still he was considered to be the physician of the pilgrim colony, and was even called in this capacity to the infant colony of Massachusetts Bay. The first record of his professional work occurs in August, 1621, when in a scrimmage with the Indians "ther was 3. sore wounded; these they brought home with them," i.e., to Plymouth, "& had their wounds drest & cured and sente home." This act of kindness had an excellent effect in the way of winning the friendship of their savage neighbours. In June or July, 1622, came the *Charity* and *Swan*, two ships sent by "Master Thomas Weston"—from whom the pilgrims suffered so much ill-usage—having in them some fifty or sixty men. During their unwelcome sojourn at Plymouth several of their number became "sick and lame," and these they left at Plymouth under Dr. Fuller's care, "although they had a surgeon of their own," Mr. Salisbury. In the winter of 1628 an epidemic appeared among the newly arrived colonists at "Naumkeag" (now Salem), in Massachusetts Bay, caused "by infection that grue amonge ye passengers at sea." Accordingly, Dr. Fuller was sent to the Bay colony, where he attended to the bodily ailments of the settlers. In the summer of 1630 Dr. Fuller was again called to Massachusetts Bay on account of the great prevalence of sickness, occasioned, says Gov. Winthrop, by "ill diet at sea." Therefore, on July 8th, he went to Matappan (now Dorchester), "and let some 20 of these people blood." On August 4th he was at Salem, and a little later at Charlestown, probably still "letting blood," and discussing theology, for he was quite as well versed in the theology of the day as he was in medicine. Soon after he wrote that "the sadd news here is that many are sick and many are dead. I here but lose time, and long to be at home. I can do them no good, for I want drugs and things fitting to work with." Further references to Dr. Fuller's medical work are few, and wherever he is subsequently mentioned he appears in the light of a theologian. In 1633 the colony was visited by an "infectious fevoure," of which, "after he had much helped others" died "Samuell, Fuller, who was their surgeon and phisician."

#### Unnecessary Operations.

It cannot be denied that at the present time there is a tendency to perform operations upon cases where, to say the least of it, operative interference is unnecessary. In this way a veritable *cacoethes operandi* grows apace. In no department of surgery is this so prevalent as in that of the nose and throat. A distinguished laryngologist has lately drawn attention to the subject in a lecture on the principles of local treatment in diseases of the upper air passages. He points out that the craze for operation is conspicuous in the case of adenoid vegetations, which came before the notice of the profession only about twenty years ago. Suddenly operation for adenoids became

the rage, and every lymphatic nodule in the pharynx was promptly removed. It must be admitted that in a severe case causing obstruction to nasal respiration, operation is not only justifiable but distinctly indicated; but many non-obstructive cases do not necessitate operation, and the adenoids often disappear spontaneously. In the case of adenoids the fault lies partly with the public, for parents ask each other if their children have been "done," as if it were a matter as necessary as vaccination. With regard to the danger of this excessive operating, in 1896 statistics were published showing that in two years and a quarter eleven deaths were reported after operation for adenoids, most of which were consequent upon the practice of obliging the anæsthetist to perform his duties with the patient in the sitting posture. Next to adenoids, perhaps operations on the nose come into the question. No one can object to a nasal spur, or other material obstacle which causes serious obstruction to breathing being removed, but every slight deviation or spur of the nasal septum does not require the saw, nor every puffiness of the turbinate bones the cautery.

#### Medical Fees in Legal Proceedings.

In another column, we report a case of much interest to the medical profession, involving the question of the fees to which medical witnesses are entitled. As it is probable the case will be brought before the Court of Appeal, we refrain from commenting upon it. We should like, however, to correct a mistake, which was made by Mr. Justice Wright in delivering judgment. He said that he had asked the question why one of the witnesses should receive anything beyond the ordinary fee, and the reply he had received was that it was because the witness was a gentleman of great eminence. Mr. Justice Wright, however considered, that to express it colloquially, "the witness received higher fees because he drove a brougham and lived in Merrion Square." Mr. Justice Wright will, we hope, pardon us if we correct him. A witness of eminence receives, and is entitled to receive, fees beyond the ordinary scale, not because he drives a pair, but, again to express it colloquially, because his market value entitles him to demand such fees. Mr. Justice Barton's remarks are more to the point:—"There was great force in the argument that one guinea a day was not a reasonable fee for a doctor, between party and party, for attendance in court." We trust that the matter will be submitted to the Court of Appeal.

#### Inmates from Inebriate Reformatories.

A CONFERENCE was held last week at the Home Office with the object of devising some scheme of voluntary assistance to inmates released from inebriate reformatories, under the presidency of Sir Kenelm Digby, the Permanent Under-Secretary of State. The conference was attended by representatives of the Bench, Church, County Council, various missions, and similar bodies. The conference was not concerned with either the establishment or maintenance of inebriates' reformatories, but with

the treatment of the inmates at a very critical period — namely, when they had undergone a period of detention in a reformatory and were set free provisionally for a time under a system of licensing. Experience teaches that when an inebriate is released after apparently very considerable progress has been towards reclaiming and reforming him, if he goes back at once to his original surroundings he is in grave danger of relapse. What is urgently required is some organised method of protecting the inebriate during this dangerous interval, and unless such a want is supplied there is considerable danger of the object of the Inebriates' Act being lost altogether. This reform is one which might easily be specially met by the representatives of the various philanthropic and religious associations. Homes already exist which might well be adapted for the purpose, and it earnestly to be hoped that the conference will succeed in arranging some method by which these homes might be brought in contact with the reformatories in order to continue and complete the good work begun in the former. The proceedings of the conference were almost entirely informal, and the various representatives present expressed their views in a conversational way, with the result that it is possible that much good will come of the interchange of opinions which took place.

#### Another Surgeon "Back from the War."

It is somewhat of a mystery why every medical man who has held any prominent position in the South African campaign should consider it his bounden duty to give a blank cheque of absolute confidence in the Government immediately on his return home. The thing has happened so often that it is now accepted as a matter of course. The base insinuation of some of the baser yellow journals, that these civilian utterances are influenced by the prospect of official honours and rewards, may be at once dismissed with contempt. For all that, it would be as well for these martial civilians "back from the war" to exercise in their speech a little more of the caution that they attach to their scientific statements. Not long ago Major Stonham, in the course of a public lecture at Maidstone, is reported to have said that "it made his blood boil to hear it alleged that Boer women and children were not well treated." Individual bad treatment of women and children by our soldiers has never been alleged. The policy of the concentration camps has been criticised, and their insanitary and defective organisation, that have led to a disproportionate mortality. Does that latter fact rouse Major Stonham's anger? If so, just at present abundant opportunities exist for airing his views in public. The facts advanced by the Government, that the Boers have insanitary habits, and are so ignorantly foolish and superstitious as regards medical matters that their usual death-rate is abnormally high, should have weighed against the policy of bringing them together in large numbers under unfavourable conditions of surveillance.

#### College Representation on the G.M.C.

THE annual meeting of the English Royal College of Surgeons is chiefly remarkable for the registration of pious opinions. The tail of the Council wags the body of the members, and the protests of the latter are listened to, usually, with gravity and politeness, and then the matter ends. Were the resolutions duly carried at former meetings to be carried out by the Governing Council of the College, the most exacting reformer would find his vocation gone as regards a score of standing grievances. It is of little use attempting to bring this ancient and autocratic body into touch with the times, however, until a radical alteration in its constitution has been made by conferring a right of electoral representation upon its members. In the absence of that form of control the resolutions passed at the annual meetings can have nothing beyond an abstract and academic interest. At the meeting held in Lincoln's Inn Fields a fortnight ago, a resolution was passed "that the representative of the College on the General Medical Council should be elected jointly by the fellows and members of ten years' standing." Were that principle to be adopted it would register one of the most practical of medical reforms that could well be imagined. Such a step would at once reduce the preponderance of the purely educational element in the College nominations to one more widely representative of the interests of the main mass of the members of the College. It is this subordination of general to particular forms of government that has led to the present defenceless position of the profession as a whole. A pure democracy may one day supplant the autocracy that now holds the Colleges and the General Medical Council in an iron grip. That appears to be the unacknowledged goal of the most active medical reformers.

#### The Alleged Cure of Cancer by X-Rays.

THE news of an alleged cure of cancer by an American medical man has, within the last few days, been busily bruited among the public newspapers on this side of the Atlantic. The particular method thus announced is by exposure to the X-rays, or rather to the tube that produces the rays, which in themselves probably possess no healing virtue of any kind whatever. There is nothing new in the treatment of cancer by the focus tube, for the plan has been upon its trial by English surgeons for many months past. The statement that the X-rays cure cancer is so utterly cruel and misleading, however, that it may be well briefly and summarily to nail the lie to the counter. That the method is able to exercise a favourable influence over the surface of an ulcerating and sloughing cancer is an acknowledged fact, but partial healing of a skin surface does not mean the cure of a deep-seated cancerous process. In a word, any man who says he can cure an internal cancer by exposure to the X or any other rays is making claims to which there is no scientific basis; in other words, he is airing falsehoods. When the cancer is of an absolutely

superficial kind, affecting only the skin, and known as an epithelioma, there is good evidence to show that it may in some instances be cured by the X-ray method. That is a very different affair from the impression that must necessarily be conveyed to the public by the general statement that cancer can be cured by the X-rays. The wisdom of publishing matters of this kind in lay newspapers is more than questionable. In order that the practice of semi-quack administrators of X-ray cures may not be swelled by the credulity of sufferers from cancer, it becomes a duty of medical journalism to sound a clear note of warning.

#### The Macclesfield Infirmary Dispute.

THE dispute between the honorary medical staff and the governors of Macclesfield Infirmary in regard to the appointment of Miss Murdoch Clark as junior house surgeon has not made any progress towards settlement. At the conference between the honorary medical staff and the board, which took place last week, the former insisted on their right, if not to appoint, at any rate to select for appointment the residents with whom they would have to work. In practice, no doubt, this custom, for custom it is, makes for harmony and efficiency, but in this particular instance the principle of the appointment of qualified women on the junior staff is at stake, and a deadlock is the result. It can hardly be doubted that at the present time the medical profession in general view the appointment of female resident medical officers with great disfavour, and in the present instance the honorary medical staff have our sympathy in so far as the general principle of their right to nominate candidates is concerned, but in so far as their objection is based on a prejudice against the appointment of qualified women we cannot support them. The paramount question, however, is the welfare of the institution, which is likely to suffer from the existing deadlock. If the staff persist in their refusal to work with a woman resident the interests of the patients demand an immediate solution—the most obvious course being the withdrawal of the “bone of contention.”

#### Medical Men and Midwives.

AN elderly woman, described as a monthly nurse, was sentenced to a term of imprisonment a few days since, at the Central Criminal Court, on a charge of manslaughter by culpable negligence. She absolutely neglected her patient and left her without assistance or directions. A medical man was sent for, but at first refused to attend because, as he subsequently explained at the inquest, he had already attended several cases with this unqualified midwife, and was afraid lest the General Medical Council should prosecute him for “covering.” The Judge was “inclined to believe” that the witness was under a misapprehension in supposing that the Council would view with disfavour his having responded to the summons. It is difficult to believe that the medical witness really laboured under this delusion, and it rather conveys the impression of

being merely an excuse for his refusal to render assistance when first applied to. If a medical man habitually employed an unqualified female assistant and placed her in sole charge of obstetrical cases, only intervening to sign the certificate of death in the event of a mishap, he might conceivably render himself liable to be hauled before the Council; but that is a very different matter to attending cases in which, from carelessness or ignorance on the part of the midwife, the case has assumed a serious aspect.

#### Scientists in a Balloon.

THE hidden energy of modern scientific observers is in some ways one of the most remarkable features of the present age. Anything that offers an opportunity of experimentation under new conditions is seized upon eagerly as though it opened up the avenues to boundless wealth instead of leading, as usually happens, to the fields of empty fame that too often await the single-minded man of science. The whole position is being at the present moment illustrated by a series of experiments recently conducted in Paris by three medical men in balloons, lent them for the occasion by the Aero Club. Their professed general purpose was to study the physiological condition of man in the upper air. One particular object was to find out whether the high altitude sickness and other phenomena were due to oxygen saturation or to alterations in blood pressure. It was hoped that the point would be determined by noting the effect of inhaling oxygen gas, and by examining the expired gases. Another set of experiments was devoted to the spectroscopic and microscopic appearances of the blood. The observation of M. Gaute, of Zurich, that there was apparently a large increase in the blood corpuscles after a rapid ascent in a balloon was to be tested. Had the proposal to throw fresh light on blood diseases by sending three learned medical men up in a balloon been advanced a generation ago the derision of the world would have been invited thereby. Nowadays, however, nothing is too new or too strange. It is possible to see the bones of one's hand through two feet of timber, why should it be impossible to find a cure for anæmia a mile or so up in the skies?

#### The Peers as Medical Advisers.

IT is curious to observe how great an amount of support is bestowed upon quacks and quacklings by members of the peerage in the United Kingdom. Mattei's cancer cures and almost every other notorious medical fraud of modern times has been pushed at one time or another by its titled admirers. Latterly we have had the claims of an unqualified bone-setter gravely upheld in public against those of the leading medical men of a provincial town. Quite seriously, too, the value of violet leaves as a cure for cancer has been proclaimed on the testimony of the sister of a belted earl. Can the persons who publish such hasty conclusions be conscious of the vast amount of groundless hope and of infinite despair and anguish they are calling into being? There is another and less harmful class of

pers who simply rail against the medical profession. Among the most amusing instances on record was that of the Duke of Portland, who, in presiding at an antivivisectionist meeting some years since, was so anxious to make out a case against the "doctors" that he defended the sacredness of sport by asserting that the latter was for the good of everyone concerned, including the hunted quarry. A week or two ago Lord Camperdown, in the course of a long, discursive speech delivered to his constituents in Forfarshire, delivered his mind of some very noblemanlike sentiments on the matter of disease. According to the *Dundee Courier*, of November 22nd, his lordship said he did not believe much in disease, and he thought it was the doctors who brought about disease very much. If this sort of thing goes much further we shall have to attach a new reading to *noblesse oblige*, so far as regards its relations with the medical profession, and with scientific medicine.

#### Red Tapeism and the Wounded.

SOME time ago a disabled soldier named McNamara sought and obtained admission to the North Dublin Union Workhouse. From the injuries he received in South Africa he became paralysed, for which he was invalided home. The doctor of the workhouse communicated with the War Office concerning the poor man's pension, and received back the intelligence that "the soldier's rate of pension was deferred until he left the Union." Being paralysed and penniless he cannot leave, he has no place to go, and is of necessity forced to remain in the workhouse. Surely under such circumstances a little common sense might be exercised in dealing with such a case. The course pursued is well calculated to make the Army unpopular in the very city which furnished some of the bravest men who went to South Africa.

#### Glucose in Marmalade.

THE question of the liability of vendors of glucose made jam and other preserves to prosecution under the Food and Drugs Act has been at length disposed of in the higher courts. Last February a Worthing grocer was convicted of unlawfully selling, to the prejudice of the purchaser, marmalade adulterated with 13 per cent. of glucose. This verdict was brought up on appeal to the West Sussex Quarter Sessions, and having been dismissed thereat was brought before the Court of Appeal. It was proved that glucose consisted of 40 per cent. of glucose, which is practically sugar, 40 per cent. of a gummy substance, dextine, and 20 per cent. of water. In the absence of a standard composition for marmalade it is not easy to see how it could be proved that any material sold under that name was not of the "nature, substance, and quality" demanded by the purchaser. The Lord Chief Justice said he would not have come to the conclusion arrived at by the Quarter Sessions, namely, that when a man asked for marmalade he thought he was going to obtain only oranges and sugar, because there were a number of other ingredients which might very properly

be put into it. In his judgment there was no evidence of any inferior quality or adulteration, in the ordinary sense of the word. The appeal was dismissed and the common-sense view adopted that glucose is a legitimate preservative for making marmalade, and presumably other jams and preserves. There are so many injurious adulterations in food that it would be a thousand pities were an important trade harassed by the imposition of restrictions that have no bearing upon the health of the public.

#### The Small-pox Epidemic in London.

THE grip of the small-pox is tightening around the population of the metropolis. At the end of last week the Metropolitan Asylums Board had to report the substantial increase of 79 cases under treatment as against the numbers of the previous week. Since August 10th no less than 864 patients have been received at the Wharf Shelter. Of that number 858 were sent on to the hospital ships, while 369 have been discharged and 136 have died. These figures show beyond a doubt that London is threatened with one of the most serious outbreaks of small-pox that has been known in recent times. At this stage of development it sounds somewhat strange to hear the announcement of the Chairman of the Asylums Board that "the time had come when they could form a pretty good idea as to the outbreak, and he believed there was going to be rather a heavy epidemic." Considering that the present development has arisen from a single case, and that the centres of infection have been multiplied by several hundredfold in an enormously large and overcrowded community, imperfectly protected by vaccination, the situation is more than grave. The worst feature of the case in modern days is the certainty of spreading the disease sooner or later to various parts of the provinces, now that intercommunication is cheap and universal.

#### Honouring the Memory of a Physician.

ON Sunday, November 17th, Senor Conde de Romanones, Minister of Public Instruction, of Spain, unveiled a tablet in Madrid which was erected in honour of Dr. Martinez Molina, in the house in which he died, 133, Calle de Atocha. The meeting was called together in the great amphitheatre of the Saint Charles Hospital, where in the presence of numerous members of the medical profession and many Court dignitaries and members of the Government, Senores Van Banberghem and Ruiz Jimenez delivered addresses on the memory of the deceased, after which the procession formed and marched to the site of the tablet, when the Minister, Senor Romanones, uncovered it.

#### Changes in the Staff at St. Bartholomew's Hospital.

WE understand that Mr. Alfred Willett, the senior surgeon at St. Bartholomew's Hospital, has just handed in to the Governors his resignation of that post, thus leaving a vacancy on the surgical staff. In the ordinary course of things, doubtless,

Mr. Cripps, the senior assistant surgeon, will "attain his majority" and succeed to the post vacated by Mr. Willett. For the vacancy upon the assistant surgical staff there are several who are eligible. The senior on the list, whether or not he competes, is Mr. Berry, a former candidate; in addition, the surgical registrar, who has just resigned that post, as well as the senior demonstrator of anatomy. The competition is certain to be keen, whoever the competitors may be, while an election of the kind at St. Bartholomew's always excites a large amount of interest, far beyond the confines of that noted institution, in medical circles.

A CORRESPONDENT of the *St. James's Gazette* relates a means of circumventing the Sale of Poisons Act, which, though ingenious, is for obvious reasons not likely to be often resorted to. A chemist, who happened to be busy when asked for some cyanide of potassium, handed some to the customer, but dissuaded him from signing the poison book, on the ground that though he dare not sell poison without complying with the law, he could give it away if he pleased without any attendant formality.

It is interesting to note that for the first time the two Royal Colleges of London and the General Medical Council were officially represented at the last Guildhall banquet. It is stated that the innovation is the result of the subject having been brought before Sir Joseph Dimdale by a member of the College of Surgeons, and it must be conceded that the inclusion of these bodies in the list of official guests is in the fitness of things.

SEVERAL cases of small-pox have occurred at the new Rowton Houses at Hammersmith, but stringent precautions have been taken to prevent the spread of the disease among the inmates. It is obviously out of the question to close these houses, since the only effect would be to disseminate possibly infected persons throughout the metropolis.

THE Fund hitherto known as the Prince of Wales' Hospital Fund will, after January 1st, 1902, take the title of King Edward's Hospital Fund for London.

#### PERSONAL.

MR. JOHN QUICK, M.R.C.S. Eng., L.S.A., has been elected an alderman of the Torquay Town Council.

MR. HENRY GARD, L.R.C.P., L.R.C.S. Edin., L.F.P.S. Glasg., has been elected a member of the Devonport Borough Council.

MR. COLSTON WINTLE, L.R.C.P. Lond., M.R.C.S. Eng., has been re-elected vice-chairman of the Bristol Health Committee.

PROFESSOR CORFIELD has been awarded the bronze medal of the Royal Society of Public Medicine of Belgium, in recognition of his devotion to public health work.

SURGEON MAJOR-GENERAL A. M. TIPPETTS has been

granted a Good Service Pension of one hundred pounds a year after forty-seven years' service in the Army Medical Department, during which period he saw much active service.

DR. MCCRAITH, of Liverpool, was last week presented with a handsome double-barrelled gun by his medical friends of the Medical Institution, on the occasion of his leaving the city to occupy a Government appointment in Old Calabar.

PROFESSOR CORFIELD, of University College, London, Consulting Sanitary Adviser to His Majesty's Office of Works, has been awarded the bronze medal of the Royal Society of Medicine of Belgium, as a recognition of his devotion to public health work.

DR. CHARLES BALFOUR STEWART left on Saturday last at the head of a special expedition dispatched by the Liverpool School of Tropical Medicine to the Gold Coast, to investigate the means of improving the conditions of health and sanitation in that deadly climate.

SURGEON-GENERAL A. F. PRESTON, who is temporarily acting as Director-General of the Army Medical Service, is to resume the post of Principal Medical Officer on the Staff of the Duke of Connaught in Ireland, on being relieved at the War Office by Surgeon-General W. Taylor, returning from India to take up the post of Director-General.

DR. T. NEVILLE, of Sloane Street, met with an accident in Hyde Park a day or two since. Some park-keepers were shooting wild duck, and the report of their guns frightened the young horse Dr. Neville was riding, and it made for the railings, rearing and falling, inflicting severe internal injuries, which necessitated his removal to St. George's Hospital.

DR. CULLINGWORTH'S term of office as obstetric physician to St. Thomas's Hospital expired some time since but he has consented to a prolongation of three years on condition that his colleague, Dr. W. H. Tate, should be appointed additional obstetric physician, to have charge of twenty-one out of the twenty-eight beds. Dr. Tate has since been appointed in that capacity.

MR. JONATHAN HUTCHINSON, F.R.S., is leaving shortly for South Africa with the object of prosecuting his researches into the etiology of leprosy, especially in respect of the transmission of the disease by the consumption of dried and badly-salted fish. He will go in the first instance to Robben Island, and, later, to Natal and Basutoland—districts which, he believes, offer exceptional opportunities for investigations in this direction.

## Manchester.

[FROM OUR OWN CORRESPONDENT.]

#### MANCHESTER AS A SCHOOL OF MEDICINE.

WHILE nothing very remarkable has happened in the Manchester medical world during the last month, there has been no less activity, scientific and social, than is usual at this busy time of the year. Among social events two popular dinners may be mentioned. One was the annual meeting at the Queen's Hotel of the Manchester Edinburgh University Club. The attendance was larger



than usual, and nearly a hundred members and guests were presided over by Dr. Baildon, of Southport. Sir Henry Littlejohn had travelled from Edinburgh to be the guest of the evening, and he delighted his old friends and new acquaintances by a speech in his most characteristic vein of anecdote and reminiscence. The yearly medical students' dinner was also most successful, with Mr. G. A. Wright in the chair. Deputations from the medical schools of Leeds and Liverpool were present and contributed to the evening's enjoyment, both by speech and song. There was a serious element in many of the speeches, both students and teachers being evidently quite determined to keep Manchester well to the front as a school of medicine. The recently-formed Students' Representative Council promises well, and may soon be found to be a more powerful body than is at present even imagined.

#### MEDULLARY NARCOSIS BY COCAINE INJECTION.

The societies have all held successful and well-attended meetings. Among many good papers, Dr. Lea's communication to the Medical Society on medullary narcosis by cocaine injection possessed, perhaps, the most interesting features. Dr. Lea gave an analysis of eighteen cases in which he had injected a sterile solution of cocaine into the lumbar region of the spinal canal. In one of these cases the subject had Cæsarean section performed by Professor Sinclair. She vomited soon after the injection, but was comfortable throughout the operation, which was completely successful. There was moderate sickness for twelve hours afterwards, and severe headache for two days. Recovery was good. Dr. Lea was able to operate with complete comfort to the patient in fifteen of the other seventeen cases. In one no discomfort was complained of during abdominal section, but during the subsequent removal of a small lipoma a small quantity of chloroform had to be used. In one case, in which blood escaped through the puncture, anaesthesia was not produced. Sickness and headache appeared to be the chief after-effects, and recovery was always good. It is probable that medullary narcosis will be found useful in many instances where general anaesthesia is undesirable, and it is desirable that all who, like Dr. Lea, have had the courage to employ the method, should publish their results.

#### THE PATHOLOGICAL SOCIETY

has lost a secretary under whose guidance its membership grew from about 250 to 460 by Dr. Kelynaek's departure to London. It is hardly likely that its present membership can be much increased, but while the style of the communications continues to be "brief, bright, and breezy," while the discussions are weighted by no considerations of age and seniority, and while the table is always covered with a goodly show of card specimens, there is no reason to expect that the great popularity of this society will decrease. Mr. Collier genially occupies the presidential chair this session.

### Correspondence.

[We do not hold ourselves responsible for the opinions of our correspondents.]

#### BANTI'S DISEASE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In the very interesting account given by your Berlin correspondent of Senator's address on this somewhat rare disease in the MEDICAL PRESS AND CIRCULAR, November 27, p. 573, it is stated on his authority that Professor Banti, of Florence, in 1894 and subsequent years drew attention to this peculiar form of persistent anaemia associated with hypertrophy of the spleen and hepatic cirrhosis, but, as a matter of fact, Guido Banti's paper, "Dell Anemia Splenica" was published much earlier, and will be found in the *Archiv. d. Senola d. Anat. Pathol.*, 1883, p. 58.

I am, Sir, yours truly,

WILLIAM MURRELL.

17, Welbeck Square, Cavenish Square, W.

#### THE VICISSITUDES OF DRUGS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Referring to the leader on this subject in your last impression, I have for many years always given sarsaparilla in chronic syphilis. A case in which all the nails were destroyed, all the hair had fallen off, and large masses of syphilitic rupia on the legs, arms, and buttocks, which had been under treatment by other physicians for months, improved at once under sarsaparilla. I made the patient buy the most expensive kind, and make himself a fresh decoction daily, of which he took a pint. I must add that the patient was taking mercury vapour baths at the same time, and was under strict dietetic treatment.

I could mention a number of similar severe cases cured. I certainly believe the sarsaparilla aided the cure. The late Mr. Henry Lee, whose success was great in the treatment of syphilis, told me he always prescribed sarsaparilla in chronic syphilis, especially with skin lesions. I am like that eminently practical physician, Dr. Murray, of Newcastle; when I prescribe a drug and it does good I never mind what may be written against it; I continue using it. Many drugs I got to know the use of when in practice in a large country district I use to-day in consulting practice, but it would be difficult to explain how they act.

I am, Sir, yours truly,

THOMAS SUTTON, M.D., M.B.C.P.Ed.

7, Manchester Square, W., November 29th, 1901.

### Special Articles.

#### THE TAXATION OF COSTS OF MEDICAL WITNESSES.

A CASE of considerable interest and practical importance to medical men throughout the United Kingdom was decided last week in the King's Bench Court, Dublin. In January last a man, of the name of Nolan brought an action against the Great Northern Railway Company on account of personal damages received by him by reason of the negligence of its servants. He won his case and was awarded £450 damages and costs. These costs were then taxed, and the Taxing Master's award issued. To several items of this award, the defendant company objected, notably to the allowances made to medical witnesses.

Counsel for the defendant company contended that Dr. Morrison, Dundalk, who attended the plaintiff after he had sustained the injuries until he was removed to a hospital, should not be allowed for three separate attendances at Dublin prior to the trial in order that he might be present at the examination of the plaintiff by the doctors engaged by the defendant company. For each of these attendances, Dr. Morrison claimed five guineas. The defendant company contended that these charges were unreasonable, and that the visits were unnecessary, the plaintiff being at that time under the care of skilled Dublin surgeons, who were called at the trial on behalf of the plaintiff, and gave evidence. Surgeon Myles and Dr. O'Carroll had also been examined on behalf of the plaintiff, and had been allowed by the Taxing Master five guineas a day for their attendance in court during the trial. The defendant company objected to these charges, and relied on the schedule of costs by which, they submitted, the Taxing Master was bound. The schedule provided that, for professional witnesses residing within five miles of the city in which a trial took place, only one guinea a day should be allowed for attendance in Court, unless in the opinion of the Taxing Master the case was an exceptional one. It was contended on behalf of the defendant company that no special or exceptional circumstances existed in this case to justify an increase of the figure allowed by the schedule.

Mr. Justice Kenny, in announcing the decision of the Court said that, with regard to the allowances to the medical witnesses the court considered they were bound by the schedule and by the decision of the Master of the Rolls in *Maconchy v. The Bank of Ireland*.

They held that Dr. Morrison's three attendances in Dublin were unreasonable, and that he should be allowed for one visit only. With regard to the attendance of medical witnesses at the trial, the Court held that under the schedule they could not allow more than one guinea per day to doctors resident within five miles of Dublin, and three guineas to doctors outside the limit. They were unable to see any exceptional circumstances in this case that would justify the Taxing Master in allowing more than the guinea a day. The Court were sensible that the tendency of these decisions was to approximate party and party costs to those between solicitor and client, but they did not see how they would be justified in allowing the doctors a greater sum than was provided for by the schedule of fees. They would not, however, be dissatisfied if the case were reviewed in the Court of Appeal.

Mr. Justice Barton, in concurring, said he considered there was a great force in the argument that one guinea a day was not a reasonable fee for a Dublin doctor between party and party for attendance in court, and that a case like the present was an exceptional one. But he thought that arguments such as these should be addressed to the Court of Appeal or to the rule-making authority. The Court considered the scale was binding on the Master even in the case of doctors of exceptional eminence.

Mr. Justice Wright also concurred. The case, he said, was one of very great importance. The plaintiff was a minor. The money had been paid into Court, and it had been stated that the medical men had been paid fully in advance. The result would be that the solicitor would have to pay the difference out of his own pocket, the difference between the sum the Court allowed and the amount that had been paid to the doctors. On the other hand the case was of immense importance to railway companies who had constantly to face claims of this kind, claims which sometimes did not rest on solid grounds, but were in fact sham claims. He had asked the question why it was in this case that medical gentlemen resident in Dublin should obtain anything beyond the ordinary scale, and the reply he had received was that Mr. Myles was a gentleman of great eminence. To use a colloquial expression, the case was a special one, because a gentleman drove a brougham with two horses and lived in Merrion Square. While the Court were conscious that their decision involved a difficulty and a hardship they could not go outside the rule. He would be glad if the Court of Appeal laid down some decision for their guidance. They would loyally follow it. The Taxing Master stated that the medical gentlemen remained a long time in Court. Sometimes medical men seemed to think that they were engaged in a duel. They remained in Court listening to the evidence for the claimant with a view—well of disproving what was said. One of the dangers arising from that was that they were apt to forget their character of witnesses to tell the truth, and to become rather advocates of the side that employed them. He did not say that their decision would have any effect in reducing that tendency, but certainly it would not encourage the doctors to remain in Court, whatever the effect of it might be.

### Literature.

#### HARRIDGE ON THE OPHTHALMOSCOPE. (a)

THIS standard guide to the principles and use of the ophthalmoscope needs no praise at our hands, its reputation is too solidly established with several generations of students. Even in the matter of revision there was little to do beyond recasting a phrase here and there, the sense of which was not as clear as one could wish. There are sixty-five illustrations and four coloured plates, the latter especially being excellent specimens of colour printing. This, the fourth, edition cannot well add to the author's reputation, which dates from the first of the series. We can cordially recommend the work to students and practitioners as a concise and

(a) "The Ophthalmoscope." By Gustavus Hartridge, F.R.C.S., Surgeon to the Royal Westminster Ophthalmic Hospital, &c., &c. Fourth edition. London: J. and A. Churchill. 1901. Price 4s. 6d.

well-arranged guide to the study of diseases of the eye as seen with the ophthalmoscope.

#### PIGG ON CLINICAL PATHOLOGY. (a)

THIS is the second edition of a very commendable guide to clinical pathology. The technical directions are given in a direct, straightforward way, without circumlocution or ambiguity, and they are sufficiently comprehensive to leave no point untouched. This branch of clinical work is one which daily assumes greater importance, and without a thorough knowledge of the *technique* no student or practitioner can keep abreast of the times. The work is interleaved with blank pages to facilitate the record of alternative methods or modifications of existing ones, and comprises a fair number of illustrations of a diagrammatic sort. The author rightly seeks to impress upon students the importance of actual practical work in this department; indeed, it has no value except in the hands of those who have trained themselves to employ the methods herein described, and to understand and interpret the lessons they convey.

#### BURDETT ON THE NURSING PROFESSION. (b)

THIS little book, indispensable to all who wish to join the profession of nursing, has already justified its existence, and is in its third year. Everything to do with nurses is included, what to do, how to do it, and where to go, with particulars of societies and institutions, the objects of which include the promotion of thrift among nurses, the raising of their status, and the institution of examinations, and the issue of diplomas in subjects which will prove useful to them in their career. The book, too, will be very valuable to hospital officials in lessening the amount of correspondence with which they are now inundated by inquirers who seek the information which it contains.

### Obituary.

#### DR. A. CAMPBELL CLARK, OF HARTWOOD.

IT is with sincere regret we have to announce the death of this gentleman, on Thursday last, at the early age of fifty. This regret is tinged with a personal sorrow, as Dr. Clark was engaged on the staff of this journal for the past fifteen years as editor of our "Lunacy Department," and as reviewer of most of the works in his specialty that appeared in these columns. Apart from his acknowledged eminence in the particular department mapped out by himself, he was a man of marked individuality, fearless in speech and absolutely upright in character.

Originally of a robust constitution, he last year had a severe attack of influenza, which was followed by visceral complications, from the effects of which he eventually succumbed. Dr. Clark was trained for a commercial life, but not finding it congenial to his tastes he proceeded to the University of Edinburgh, where he studied medicine and graduated a bachelor of medicine and master of surgery in 1878. He obtained his M.D. degree in 1886, graduating with honours. His first experience of the active duties of his profession was at Melrose Asylum, where he was appointed assistant medical officer. After a few months were spent there he was promoted to be an assistant to Dr. Clouston, of Morningside Asylum. Here he gained considerable experience of and insight into lunacy work, and turned his opportunities to such good account that he was appointed Medical Superintendent to Kirkland's Asylum, Lanarkshire, at a comparatively early age, where he soon distinguished himself by writing

(a) "Clinical Pathology and Practical Morbid Histology." By T. Strangeway Pigg, M.A., Demonstrator of Pathology in the University of Cambridge. Second Edition. London: Strangeway and Sons. 1901.

(b) "The Nursing Profession—How and Where to Train: being a Guide to Training for the Profession of a Nurse, with Particulars of Nurse Training Schools in the United Kingdom and Abroad, and an Outline of the Principal Laws affecting Nurses, &c." Edited by Sir Henry Burdett, K.C.B., &c. Third Year. London: The Scientific Press, Limited. 1901. Price 2s. net.

numerous original papers on mental diseases, which appeared at the time in these columns and in the pages of the *Journal of Mental Science*. On the completion of the new Lanark District Asylum at Hartwood, Dr. Clark was elected the first Medical Superintendent in 1895. This asylum has accommodation for over 900 patients, and is regarded as a model of equipment and management. Dr. Clark held various important appointments. Among others he was Professor of Psychological Medicine at St. Mungo's College, Glasgow, and was President of the Caledonian Medical Society, which held its annual meeting this year in Glasgow. On his sick bed Dr. Clark prepared his presidential address, which lent a pathetic value to its genuine picture of Celtic character and influence. In 1897, Dr. Clark published his *magnum opus*, entitled a "Clinical Manual of Mental Disease," which is highly esteemed for its practical and original character, and much used as a class-book by medical students. We believe it was mainly through his initiative that the "Handbook for Attendants on the Insane" was compiled by a committee of the Medico Psychological Association. This book has been enormously successful, and is the acknowledged authority throughout the United Kingdom and in many of the asylums of America. Dr. Clark's clear judgment and vigorous intellect will be greatly missed both by the Association, and in the large Institution over which he presided, and in his death we feel the loss of an excellent colleague and sincere friend.

## Medical News.

### A Charwoman Abortinist.

A CHARWOMAN, aged 58, was sentenced to six months' imprisonment at the Leicester Assizes last week for procuring abortion by the aid of a wooden skewer, which had for effect to render her "patient" very ill. It was stated that the prisoner was in the habit of rendering assistance of this kind. It is rather odd, by the way, that women who solicit the commission of this criminal act should escape scot free in spite of the fact that by law they are equally guilty. Incitation to procure abortion is of itself a very grave offence.

### The Irish Medical Schools' and Graduates' Association.

THE autumn dinner of this prosperous association took place last week in the Victoria Hall of the Hotel Cecil, upwards of a hundred ladies and gentlemen being present. Dr. William Alexander, of Liverpool, the president of the association, occupied the chair, and among those present were:—Sir Charles Crosthwaite, the Hon. H. B. Lefroy, Agent-General for Western Australia; Inspector-General Turnbull, R.N.; Inspector-General Lloyd, R.N., Hon. Surgeon to the King; Surgeon-General Preston, Surgeon-General Sibthorpe, C.B.; Dr. Robert Barnes, Judge J. A. Rentoul, M.P.; Professor C. B. Ball, Dublin; Dr. P. S. Abraham, Mr. Atherley Jones, K.C., M.P.; Lieutenant-Colonel Boileau, Dr. James Stewart, hon. sec.; Dr. J. H. Swanton, hon. sec.; Mr. Freyer, chairman of the Council; Dr. R. Jocelyn Swan, hon. treasurer; and Dr. Irwin Scott, vice-president of the Council. After the usual loyal toasts, Professor Ball, of Dublin, proposed the toast of "Our Defenders," and, in doing so, he voiced the hope that ere long they would be able to welcome the Army back in peace with honour. Addressing himself to the position of the Royal Army Medical Corps, he said that though there had been much hostile criticism of the treatment of the sick and wounded, it was admitted on all hands that the members of that corps had done their utmost. He admitted that the Service had not of late been as popular as of yore, but an attempt had been made by the Government to remove some of the more serious causes of dissatisfaction, and though the attempt had been received in many different ways, his belief was that the scheme was worthy of a trial, and would have the effect of improving the Service very materially. Inspector-General Turnbull replied for the Navy, Lieutenant Colonel C. J. Whitaker for the Army, and Surgeon-Captain Sleman, Senior Medical Officer of the City Imperial Volunteers, for the Volunteers. Captain

Sleman said that when at Pretoria he had a good many sick, and they all wanted to go to the Irish Hospital because of its splendid reputation. Inspector-General Lloyd, R.N., proposed the toast of "Our Guardians," associating it with the names of Sir Charles Crosthwaite, Judge Rentoul, M.P., and Mr. Atherley Jones, K.C., M.P. The intervals between the toasts were enlivened by some excellent vocal and instrumental music rendered by Mr. James Dunn, Miss Jessica Lawson, Miss Elsie Southgate, Mr. J. L. Shine, and Mr. Arthur Helmore.

### The Notification of Phthisis.

THE Local Government Board dissents from the proposal of the Halifax Town Council to include phthisis in the list of compulsory notifiable diseases, pointing out that it is open to the Council to enter into an arrangement with the local practitioners for the voluntary notification of this particular disease, a step which does not require the sanction of the Board. The Town Clerk has asked the Board to refer the Council to the statute which authorises the Corporation to pay fees for voluntary notification.

### Drastic Anti-Phthisical Measures.

THE immigration authorities of New York have decided to deport consumptive immigrants, and their action has been supported by the Circuit Court in respect to one Boden, who, after residing for four years in Philadelphia, recently returned from Ireland suffering from pulmonary tuberculosis.

### London's Milk Supply.

THE report of the committee which has been investigating the question of preservatives and colouring matter in food and milk recommends the total prohibition of the use of preservatives in milk. From inquiries made it would appear that the regulation would be welcomed by Welford's and other leading dairies of London, if only because it would in no way apply to them. The net result would be that those dealers who did use preservatives would be compulsorily levelled up to those who did not. This might at first curtail the milk supply of London, but it should have no permanent effect in that direction. Naturally the large concerns have an advantage over small dealers, because they are able to turn their surplus milk into butter and cheese, and hence have no need to use preservatives.

### Toxic Insect Powder.

A MIXTURE of roburite and insect powder is a parasiticide much used in the mining districts, but its employment appears to be fraught with danger. A few days since a miner and his family were removed to the Wigan Infirmary, suffering from symptoms of irritant poisoning, and enquiry showed that these were due to the use of the above mixture to kill fleas, the heat and moisture of the bed having favoured absorption and inhalation of the nitrous fumes. The sufferers are now on the road to recovery.

### Unexplained Death of a Medical Student.

AN inquest was held by the Coroner for Westminster on the 27th ult. on the body of Humphry Warrington Hayward, who had died under peculiar circumstances. According to the medical evidence nothing was found at the autopsy to account for death, and as no unnatural cause could be alleged, a verdict of "Death from natural causes" was returned.

### Arrest of a Wigan Practitioner.

MR. JAMES J. P. D. O'DONNELL, described as a medical man, recently in practice at Wigan, was arrested at Birmingham last week, on a charge of stealing postal orders for £26 6s. He gave a false name, but was identified by extensive tattoo marks on both arms.

### Death under Chloroform.

A DEATH under chloroform at St. Bartholomew's Hospital was the subject of an inquest last week, the victim being a man about to undergo an operation for a cancerous growth in the mouth. The anæsthetic was administered by Dr. Gill, who stated that this was only the third death he had had in 40,000 cases. It is obvious that death on the operating table may sometimes be of the nature of a simple coincidence, and the explanation is one which may readily be conceded when the proportion of deaths is as low as this.

## Notices to Correspondents, Short Letters, &c.

**✉** CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive signature* or *initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

Dr. J. D. E. M.—A review of your book is in type awaiting space.

Mr. STUART MONTEATH.—We are unable to insert your letter in its present involved and obscure phraseology.

Dr. RABAGLIATI's case of "Submucous Myomectomy" is marked for early insertion.

M.B.C.S. (Manchester).—You will find a similar point to your<sup>s</sup> in regard to fees is discussed in our present number, and a recent case in illustration, with the remarks of three judges thereon.

### ROYAL MEDICAL BENEVOLENT COLLEGE.

Two female scholarships, providing free education and maintenance at the School of St. Ann's Society in connection with this College, will shortly take place. In one case the presentation is for the necessitous orphan daughter of a medical man who has been in independent practice in England or Wales for not less than five years; in the other case the restrictions are different, but the presentation is limited to the daughter of a medical man. Further particulars will be found in our advertisement columns.

**AN AGGRIEVED PRACTITIONER.**—The Autumn Session of the General Medical Council is now on, but we hardly think your case is one this body could deal with. Looked at with a charitable eye, the act might be taken as one of thoughtlessness rather than wilfulness. We can, however, understand the annoyance it has caused you.

**OUR VIENNA CORRESPONDENT.**—The receipt of Erlich's paper on "The Theory of Hematic Antidotes" is acknowledged with thanks.

Dr. W.—The questions at issue between you and your partner are ordinary matters of custom, and should be capable of adjustment at the hands of an arbitrator, to be mutually agreed upon. The legal remedy open to you is not only very costly, but necessarily involves a cumbersome and often ineffectual procedure.

## Meetings of the Societies.

### LONDON.

WEDNESDAY, DEC. 4TH.

**OBSTETRICAL SOCIETY OF LONDON** (20, Hanover Square, W.).—8 p.m. Specimens will be shown by the President (Dr. Horrocks), Mr. Maxwell, Dr. Wilson, Dr. A. Routh, Dr. Stannus (introduced by Dr. Tate), and Dr. Lockyer. Dr. Griffith will show a Person of Uncertain Sex. Papers.—Dr. R. Sanderson: A Case of combined Vaginal and Abdominal Hysterectomy for a Pregnancy of four and a half months complicated by Cancer of the Cervix.

THURSDAY, DEC. 5TH.

**HARVEIAN SOCIETY OF LONDON** (Stafford Rooms, Titchborne Street, Edgware Road, W.).—8.30 p.m. Mr. C. W. Mansell Moulin: Some Unusual Effects of Movable Kidney.

**CHILDHOOD SOCIETY** (Library of the Sanitary Institute, Margaret Street, W.).—8 p.m. Lecture.

**RONTGEN SOCIETY** (20, Hanover Square, W.).—8.30 p.m. Mr. J. H. Edwards: Bullets and their Billets: Experiences with X-rays in South Africa.

**NORTH-EAST LONDON CLINICAL SOCIETY** (Tottenham Hospital).—4 p.m. Clinical Cases.

FRIDAY, DEC. 6TH.

**WEST LONDON MEDICO-CHIRURGICAL SOCIETY** (West London Hospital, Hammersmith Road, W.).—8 p.m. Clinical Meeting.

**WEST KENT MEDICO-CHIRURGICAL SOCIETY** (Royal Kent Dispensary, Greenwich Road, S.E.).—8.45 p.m. Dr. J. F. Goodhart: General Practice and Original Research. (Purvis Oration.) Conversazione. Exhibitions of Lantern Views of Foreign Health Resorts, Electrical and Scientific Apparatus, Surgical Instruments, Therapeutic Preparations, Diabetic Foods, &c.

**LARYNGOLOGICAL SOCIETY OF LONDON** (20, Hanover Square, W.).—5 p.m. Cases will be shown by Mr. Lawrence, Mr. Lake, Dr. Kelson, Dr. Horne, Dr. Potter, and Mr. Waggett.

### DUBLIN.

WEDNESDAY, DEC. 4TH.

Clinical Meeting, Pharmaceutical Society, 4 p.m.

THURSDAY, DEC. 5TH.

Council Meeting, Royal College of Surgeons.  
Dublin University Biological Association, Front Hall, Trinity College. 8.15 p.m.

FRIDAY, DEC. 6TH.

Royal Academy of Medicine in Ireland. Section of Surgery (Royal College of Surgeons), at 8.30 p.m. Papers will be read by Mr. J. S. McArdle, on Intracranial Hemorrhage; Mr. E. L. Swan, on The Surgical Treatment of Chronic Synovitis; and Mr. T. E. Gordon, on a Successful Case of Pylorotomy. Living Exhibits—1. Mr. D. Kennedy (a) Case of Enlarged Liver after Trauma, (b) Two Cases showing Results of Osteotomy for Bow Leg. 2. Mr. R. L. Swan, Case of Bilateral Radical Cure of Inguinal Hernia, with interval of four years between operations. 3. Mr. Henry Croly, Patient operated on for Double Empyema. Card Specimens—1. Mr. H. Gray Croly (a) Stomach Lacerated by Shaft of Dray (cycle accident), (b) Limb Removed by Amputation at Hip-Joint. (2) Mr. D. Kennedy (a) Thymus and Thyroid Glands of Child who died under Chloroform, (b) Four Skiagrams showing Foreign Body in Oesophagus, Stone in Bladder, Congenital absence of Radius and Fracture of Forearm. 3. Mr. E. L. Swan (a) Two Kidneys with

Enlarged Ureter removed from patients, aged 23 and 35. (b) Comminuted Extra-Capular Fracture of Femur removed from Body of Man, *et. 90*, three days after injury. 4. Mr. Henry Croly (a) Tumour removed from Infra-Scapular Region, (b) Cystic Hygroma.

## Appointments.

BROWN, E. ARCHER, M.B. Edin., M.R.C.S., Medical Officer to one of the Transvaal Concentration Camps.

CUTHBERT, W. H., L.R.C.P., L.R.C.S., Medical Officer of Health under the Frinton-on-Sea Urban District Council.

DONALDSON, WILLIAM IRELAND, B.A., M.D. Univ. Dub., Medical Superintendent to the London County Asylum, Epsom.

KENNEDY, T. B., M.R.C.S., B.Ch., B.A.O.R.U.I., Junior House Surgeon to the Miller Hospital and Royal Kent Dispensary.

LONG, SYDNEY H., M.B. Cantab., Physician to the Jenny Lind Infirmary for Sick Children, Norwich.

NICHOI, F. E., M.B. Cantab., Certifying Surgeon under the Factory Acts for the Margate District of Kent.

PEACOCK, C., M.B., B.Ch., B.A.O.R.U.I., Senior House Surgeon to the Miller Hospital and Royal Kent Dispensary.

PERKINS, PHILIP MYTLER, M.B., B.S., M.R.C.S., House Physician to the Sussex County Hospital, Brighton.

PRESTON, L. L., M.B. Durh., M.R.C.S., Medical Officer of Health under the St. Helens Urban District Council.

SECCOMB, J. W. S., M.R.C.S., L.R.C.P., Junior House Surgeon to the Radcliffe Infirmary, Oxford.

## Vacancies.

Bethlem Hospital.—Two Resident House Physicians recently qualified in Medicine and Surgery. Term six months from January 1st next. Apartments, complete board, and washing provided, and an honorarium at the rate of £25 each per quarter will be paid. (See Advt.)

Bradford Children's Hospital.—House Surgeon. Salary £100, with board, residence, and washing. Applications to the Secretary.

Bradford Royal Infirmary.—Dispensary Surgeon to visit patients at their own homes. Salary £100 per annum, with board and residence. Applications to the Secretary.

Clifden Union.—Medical Officer. Salary £150 per annum, and £10 a year as Medical Officer of Health, together with the usual registration and vaccination fees. Applications to F. King, Clerk of Union. (See Advt.)

County Asylum, Rainhill, near Liverpool.—Assistant Medical Officer. Salary commences at £150 per annum, with apartments, board, attendance, and washing. Applications to the Medical Superintendent.

Down District Lunatic Asylum.—Assistant Medical Officer. Salary commencing at £150 per annum, with board, apartments, washing, &c. Applications to be addressed to the Resident Medical Superintendent. (See Advt.)

Nottingham General Hospital.—House Surgeon. Salary commencing at £100, with board, lodging, and washing. Applications to the Secretary.

Notts County Lunatic Asylum, Sneinton, Nottingham.—Medical Superintendent. Salary £800 per annum, with furnished house, coal, light, washing, and garden produce. Forms of John Frederick Gell, Clerk to the Committee of Visitors.

Royal Hospital for Incurables, Donnybrook, Dublin.—Resident Medical Officer. Salary £100 per annum, with board and apartments. Applications to J. J. Thompson, Esq. (See Advt.)

Staffordshire General Infirmary.—House Surgeon. Applications to the Secretary. Salary £120 per annum, with board.

## Births.

DrAKE.—On the 28th ult., at Rathgar Cottage, Streatham, Surrey, the wife of Courtenay H. Drake, F.R.C.S., of a son.

POTTS.—On Nov. 27th, at 180, Hagley Road, Edgbaston, Birmingham, the wife of W. A. Potts, M.D., of a son.

## Marriages.

GENGE—WHEELDON.—On Nov. 28th, at St. Werburgh's Church, Derby, George Gilbert Genge, M.D., B.S., of Lansdowne Road, Croydon, son of the Rev. E. H. Genge, M.A., to Catherine, second daughter of the late George Wheeldon, of Park Fields, Dorby.

JONES—DIXON.—On Nov. 28th, at St. Matthew's Church, Exeter, Robert Orford Jones, L.R.C.P., L.R.C.S., of Slapton, Devon, son of John Thomas Jones, M.D., M.R.C.P., of London, to Mrs. Ellen Flower Dixon, of Kingsbridge, Devon.

McLOUGHLIN—HARRISON.—On Nov. 21st, at St. Mary's Great Chart, Kent, Captain George Somers McLoughlin, D.S.O., R.A.M.C., to Audrey Katherine, eldest daughter of the Rev. Alban H. Harrison, Rector of Great Chart.

ZIMMERMANN—WATLING.—On Oct. 26th, at Holy Trinity Church, Murree, Punjab, India, Major B. F. Zimmermann, R.A.M.C., to Ethel Marian, eldest daughter of the late Colonel J. T. Watling.

## Deaths.

BAILEY.—On Nov. 24th, at Ampton Street, London, W.C., John Andrew, Bailey, M.R.C.S., L.S.A., aged 72 years.

KING.—On Nov. 25th, at Boyfield House, Moulton, Spalding, Robert King, M.B. Cantab., F.R.C.P. Lond., aged 59 years.

PRINCE.—On Nov. 25th, at 10, Warwick Road, Maida Hill, W., after a short illness, Arthur Prince, M.R.C.S., L.R.C.P., in his 67th year.

WILDBORE.—On Nov. 26th, at his residence, 2, Brunswick Road, Hove, Sussex, Frederick Wildbore, late Assistant Surgeon, Coldstream Guards, aged 79 years.

# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXIII

WEDNESDAY, DECEMBER 11, 1901.

No. 24.

## Clinical Lecture.

### FATTY TUMOURS

AND

### GENERAL ADIPOSITY. (a)

By JONATHAN HUTCHINSON, F.R.C.S., F.R.S.,  
Consulting Surgeon to the London Hospital.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

GENTLEMEN,—To-day we change our subject rather abruptly from diseases of vegetables to the occurrence of increase of fat in the human subject, but I give one little connecting link between the two topics which is of interest. I did not mention in my last lecture the occurrence of the tumours which are not very infrequent in some species of vegetables and trees more especially in the beech, in which a little, marble-like nodule develops under the bark, consisting of wood, and having no connection with the woody stem of the tree. The interesting point in reference to the development of these knots, as they are sometimes called is that they are not knots in the sense in which that term is used in reference to some other structures. You are all familiar with them. What is the explanation of their development? I believe it is this—that in connection with a large stem, there is developed a small leaf-bud, which attempts to grow out in connection with the cambium. That leaf-bud, owing to some deficiency in its supply of sap and in its connection with the tree, gets struck off and covered in by the bark. It is detached, its base narrowed, and in the end there remains only an embedded bud, and here we have proof of the vital tendencies of tissues—this piece of potential bud continues, although it has no object to fulfil in connection with the tree, to grow into a little rounded woody mass, covered in by the bark, and this mass will form layer upon layer of wood. Sometimes it may retain a very small base of attachment to the outer part of the stem. I have a very beautiful specimen which I obtained a few weeks ago from a large fir tree, where they are not very common. It was knocked off and had no structural connection with the tree. On cutting a section you saw layer after layer of wood tissue, as in the stem of a tree. It affords a curious instance of tissue endowed with life, for although it can no longer develop for the good of the whole structure, it cannot help going on growing. It is not absolutely dead. In reference to ordinary fatty tumours their importance is very great, and also to malignant tumours. The explanation of the occurrence of what are commonly called fatty tumours is that a little piece of fat is entirely dissociated from the general adipose tissue, and is no longer in structural continuity with the cellular tissue in which it is embedded, and this fatty detachment may grow at a very early period of life. It is supposed in cancerous tumours that a little piece of foetal tissue gets encysted so that it no longer undergoes the ordinary laws of development, but remains isolated, and may later on grow

into a cancer. In the simple cases of ordinary lipoma, or fatty tumours, my suggestion is that in all probability, during the primary development of the infant, little bits of fat become separated from the other fatty tissue and get encapsuled, then they grow not necessarily early in childhood—for fatty tumours very rarely occur then—but at some period long after childhood. This suggestion may apply to other tumours as well. That leads me to this statement that an isolated fatty tumour has a shell which is quite detached from the adipose tissue in which it is developed, and that tells us they can be enucleated. I will not go into the general surgical relations of fatty tumours. Their diagnosis is perfectly easy. They are semi-fluctuating and very soft. They do not contain fluid, and you must not mistake them for such a tumour. If you press the tumour so that the borders bulge a certain amount of lobulation occurs, and that is the diagnostic point. They occur on the shoulders or they may develop in any part of the body where there is fat. They are extremely rare in the scrotum on account of the non-occurrence of fat there. They are, however, extremely rare in the orbit, although it is full of fat. It may be that the fat in the orbit is serving a more definite physiological purpose than the fat in other parts of the body. It supports the eyeball and is much less liable to vary in quantity than the fat in other parts of the body.

Since the tumours are encapsuled, it is not necessary for the surgeon to dissect them out. You have to cut freely into the capsule in which they are embedded and their coat, then they can be turned out very easily if the capsule is well opened. In enucleating a fatty tumour take your knife and squeeze up the fatty tumour quite tight in one hand, and, with a good long sweep of the knife, cut right into the tumour. Do not attempt to cut round it, because if you do you will have a long dissection to perform. This is all I have to say respecting what is ordinarily called a fatty tumour. But it is a very small part of the general subject which I purpose to make some remarks on; that is as to the conditions under which fat may vary in the animal organs. We have the term lipomatosis as designating the tendency to the general increase of fat. We have several curious forms of this tendency, and I will take first that which is most closely related to the isolated fatty tumour. You have all seen the symptoms which constitute diffuse lipoma. There is no tendency to general hypertrophy of the fat all over, but in certain definite parts, such as the back of the head, which is a common place for it. Great masses of fat also form under the chin, on the neck and the pubes, where it may surround and bury the penis; in these cases the fat is not isolated as in a fatty tumour but is continuous with the fat of the surrounding parts. Here, if you purpose operating, it will be no use cutting into the tumour, for it has no capsule; but you will have to cut into the subcutaneous fat and dissect it away because the mass has no limiting membrane at all. These masses are of enormous size sometimes. You may have passed men in the streets with huge growths disfiguring the neck. The human being is far more frequently attacked than the lower animals. I have only once been consulted on

(a) Delivered at the London Hospital on July 17th, 1901.

account of the inconvenience caused by hypertrophy of fat in the pubic region. The mass was visible through the clothes of the patient, who had no general tendency to become corpulent. Such cases of local aggregation of fat and local hypertrophy of fatty tumours occur commonly in men. I have never seen a definite case of it in a woman. They occur in men and in connection generally with a cause, and that is diet. They are nearly always men who have been accustomed to drink malt liquor very freely, and the patients generally come to recognise the fact that if they abstain from drink they can diminish the size and growth of the fatty tumour very considerably. But they are not inclined to adopt that mode of treatment. We learn then that the tendency to increase of fat is under the influence of diet. That, again, is generally recognised as regards general obesity. *A priori* we should scarcely expect to find such a definite bearing in these local growths. They are attended by no serious symptoms, but the disfigurement they cause is very great. The breathing is unaffected in the majority of cases.

Ought one to operate in such cases? Well, that depends on the wish of the patient; if he has tried abstinence and found it of no avail, or if the disfigurement is very great, it is quite a justifiable case for the surgeon's interference. In operating the surgeon will have difficulty in knowing when he must stop, for there is no limit to the fat, which gradually merges into the surrounding regions. The patient will probably do well. The wound is a very large one, involving probably the whole of the back of the neck. These large skin wounds, in my experience, give increased liability to the risk of erysipelas. For that reason I am always a little cautious in urging on a patient an operation which will involve an extensive area of skin. In spite of antiseptic measures you cannot always prevent erysipelas. In a few extreme cases the patient has been pleased with the result. It is better not to do the operation at one sitting. The patient to whom I have referred was admitted to the London Hospital and operated upon, the operation was followed by an attack of erysipelas, which he survived, and he is now pleased with the results. He has still a mass on the neck. He is engaged as an auctioneer's assistant and sells horses, and consequently he is one of a class who drink very freely. He did abstain, and found it gave beneficial results. I need only mention to you the names of Rolands and MacCormac to call to your mind their writings on the subject. I have recorded a good many cases myself.

Perhaps this will be a good place for me to speak of the general influence of diet in respect to obesity. We get far more examples of general obesity, *i.e.*, increase of fat in all parts of the body, though not necessarily an equal increase in all parts, in connection very frequently with diet, but not invariably. In a great many cases of extreme obesity it would not appear that diet has much to do with it. In the majority of the less extreme cases I think on questioning the patient you would find reason to believe that beer-drinking habits in connection with the consumption of fatty, starchy, and succulent matters are important factors. Race is also a contributing factor. The Kaffirs and Zulus are fat people; some of them extremely fat, with pendulous breasts like a woman's, not due to hypertrophy of the mammary glandular tissue, but to the increase of fat around the mammary gland. As we all know, this region in both sexes is one in which fat accumulates. It is fairly common in elderly men for the breasts to assume almost the appearance of a female breast. If you were to cut such a breast across, you would find exceedingly little mammary glandular tissue. In women, as age advances, there is the same tendency to fatness, but here again it is not enlarged mammary glandular tissue, but the enormous quantity of fat upon it. Sometimes in dissecting out a mass of scirrhous you will find around the growth a very small quantity of mammary glandular tissue; what before operation looked like an enormous gland turns out to be fat. The tumour and the fat had taken its place. We have here an instance of the influence of the local structural peculiarities in regard to increase of fat.

Negroes get very fat, and this is due, not only to the

race tendency, but to their beer, which is an exceedingly fattening thing. It is quite thick, and contains more unfermented matters than our own beer. It is as much a food as a liquid. The negroes drink large quantities of it. They also consume a large quantity of sugar.

There are some races, just as there are some animals, which do not fatten. A pig easily puts on flesh in great quantity. But it is exceedingly difficult to fatten a goat, although a sheep will easily fatten. Some families have a tendency to fatten. In South Africa most of the races have this tendency, especially the Boer women, who almost invariably lose their front teeth at the age of 30-35. The men do not fatten to such a great extent, and it is said that they keep their teeth. I am unaware if there is any connection between the loss of teeth and the increase of fat.

Now I have to make one other suggestion, which takes us into another department of physiology, in reference to the tendency to the accumulation of fat, and that is it has some relation to the sexual system. That, of course, is well-known to cattle breeders. The ovaries or the testes may be removed from an animal which has been allowed to retain them to adult life with a view to increase its tendency to put on fat. A sow has her ovaries removed to fatten her; in this way all sexual excitement is done away with. The tendency to leanness is proportionate to the physiological use of the sexual system and to sexual excitement. Very few persons with highly-developed sexual habits will tend to put on fat to any large extent. With the suppression of the sexual system of function there comes a most definite tendency to fatness, especially about the mammary region; this is not infrequently the case in quite young persons. Some young men get abnormally fat: you will find very probably the sexual system is in abeyance, the testes very small, and non-development of sexual hair. I will not go further into the subject than to hint at the definite relationship between the sexual function and the tendency to fatten, and that then a definite group of cases occurring chiefly in young men in which the sexual system remains in abeyance. The voice is weak. The mammary glands become enormous apparently, though, as I have said, the fat accumulates round the glandular tissue. Of such cases I have seen very remarkable examples, and they are not attended usually with high intellectual development. Patients in whom the sexual system is partially suppressed and the growth of fat enormous are more or less wanting in mental energy. Then again we have curious cases in the female sex of this. In men, so far as my experience goes, the cases to which I have just referred begin in quite early life to fatten. In women the sexual function may be suppressed, and we may have almost an acute tendency to lipomatosis in a girl, hitherto perfectly healthy, who has menstruated regularly; she may suddenly have a complete suspension of the menstrual periods, and will put on fat to an enormous extent. I have in my mind a very remarkable case. A young lady was brought to me from a country town, very well developed, being very nearly six feet in height. At the age of eighteen, menstruation was suspended and she began to fatten. In connection with the development of fat there is one symptom to be mentioned, and that is the development of subcutaneous scars in the skin. Here let us refer again to vegetable pathology. Scars in the bark of the tree are caused by the growth of the tree being greater than that of the bark, consequently the bark is unable to stand the pressure from within and it is torn in its deeper parts; scars result from the tear. Gardeners cut a slash in the bark to allow the tree to expand. Usually the growth of both bark and tree occurs *pari passu*. But it is not so in these cases of abnormal fatness. Scars result on the skin of those patients—exactly similar to those on the abdomen of a woman who has borne children—whose accumulation of fat has a tendency to vary in amount; and those who have a slight temporary tendency to fatten in certain parts of the body are infinitely more frequently met with than the extreme cases. You will often find these scars occurring in patients who have never definitely been out of health on the hips or shoulders or other parts of the body;

then you may be sure that, at some time or other, he has had a tendency to fatten more than his skin would conveniently allow.

To return to the young lady who fattened in all parts of the body; she was slashed all over her body with long florid scars; she was covered with them. She was in a deplorable condition and I need not say extremely disfigured. In anticipation of any remarks on treatment I will add that extract of opium appeared to do her a very great deal of good. She went to many consultants and tried everything. She became very weak and lethargic and appeared likely to die. She has regained her health and menstruation has recommenced. I do not attribute the arrest of the tendency to fatten to the opium, but to the restoration of menstruation. The quantity of accumulated fat has diminished.

A fat person never lives to old age, as debility in some form ensues. The heart may become embarrassed; there may be fatty degeneration of the muscular substance of the heart, and we distinguish that from the accumulation of fat about it, but the latter is not to be wholly disregarded. In these cases of general lipomatosis, there is a large accumulation of fat about the heart, and the heart is thereby more or less enfeebled. Fatty degeneration may occur in the heart in a person who has no tendency to accumulate adipose tissue. The occurrence of heart disease in a fat patient is a frequent source of danger as regards life; with regard to the extreme cases of obesity they are exposed to all sorts of risks and dangers. A list of cases of enormous increase of fat, such, for instance, as that of Daniel Lambert, is given in an interesting book published in America by Mr. Gould. This list contains the names of more males than females. Young girls of eight or nine years of age, with a tendency to fatness, have all the appearance of a girl of fifteen or sixteen. These fat children never live very long. I know of no recorded examples. They may live to grow up, but never to old age. Cases of congenital corpulency are as inexplicable as those of congenital dwarfs. Somelight has recently been thrown on the question of great growth, irrespective of general adipose tissue increase, in connecting it with the pituitary body which has some power of regulating growth, just as it tends to produce the symptoms in the disease known as acromegaly, where it is now proved in all cases that the pituitary body is larger than normal; so it may be that we shall find that there is some part of the brain structure which presides over the tendency to fatten. It has been connected with the thyroid body, and it was thought the use of thyroid extract would prevent the accumulation of fat. I do not believe this; you are far more likely to half poison your patient with it and cause great loss of strength. In the young lady I have mentioned thyroid extract signally failed, although we made her ill with it.

As regards the weight which may be attained it is enormous. There is an instance on record of a congenital case in a child about fourteen years of age, who was so fat that she could not get out of the door of her room. But history does not tell us the size of the door. Mr. Gould, in his list, tells how some of these patients met their death. In some, death was quite accidental. The great quantity of fat embarrasses movement and respiration, and one woman, when in bed, turned over on her face and was found suffocated; she was unable to turn over again to breathe. Many have very nearly met their death in that way; to avoid this, they sleep in an erect position, and even then some are believed to die from the pressure on the trachea and its consequent embarrassment. In one case, to prevent suffocation, a rather rough measure was taken. Needles were put into the back of the chair in which the patient slept to prevent his leaning back and getting into a sound sleep.

A word or two now as to the occurrence of diffuse lipomatosis as a congenital thing. We see these cases in children who are exhibited at shows. There seems to be no clear explanation to give in regard to the enormous increase of fat. It is very seldom a family possession. Now and then two members of the same family are affected with it together, but generally there is only one.

It may be present within a very short period of birth if there is a distinct tendency to it, irrespective of any supervening conditions after birth. It is peculiar that there is no proportionate increase of appetite or consumption of food. It is seldom much larger than natural. With the tendency to fatness there is also a tendency to precocious developments in other respects. I have hinted there are many cases where the sexual function is suppressed in which there is an early tendency to fat. The enormous weight of sixty stones is recorded against one of the cases of general diffuse lipomatosis, and that occurred in a negress. It is, I believe, the greatest weight of a human being on record. Daniel Lambert weighed eight stones less, and several others have attained weights very nearly approaching these. In most cases the sufferers become lethargic, and there is almost always a great tendency to sleepiness. In some cases, on the other hand, there is a fair amount of mental activity. In Daniel Lambert the intelligence was about the average, and he retained for the greater part of his life a considerable amount of cheerfulness.

Quite recently a new affection has been described under the term *lipomatosis dolorosa*. In ordinary lipomatosis there is no pain. To the future must be left the question whether this supposed new form of the disease will stand examination. I believe a Dr. Dalton, a physician in Philadelphia, has described cases under this name, and their distinctive feature is the repeated complaint on the part of the patient of aching in the affected parts. The amount of lipomatosis in this form of the affection does not approach that which occurs in the other cases, and is often local, being confined to the breast and the lower part of the abdomen. Pendulousness of the former may cause pain. This painful form of the disease has probably some relation to myxodema, where the subcutaneous cellular tissue increases or becomes charged with some poisonous substance. I must say that I have had no opportunity of observing any of these so-called cases of the painful form of lipomatosis. The other cases where there is a great increase of fat are to be distinguished from myxodema by such signs as the absence of the peculiar facial expression and the general condition of health. There is no loss of hair in the former.

Now a few words as to the converse picture. I refer to the living skeletons, in whom the subcutaneous fat is remarkably absent, and let us also turn to the conditions under which it may occur. It is more commonly found in connection with women than with men. Extreme emaciation may happen very often in association with some repression of the sexual function. In some young women, who become abnormally lean, there is absence of menstruation. The condition of leanness may occur coincidentally with very fair health, just as in the cases of extreme fatness and good health.

With regard to one young woman who was enormously fat, and in whom there was no arrest of the sexual function, she married and became a mother of several children, and enjoyed very fair health. Such cases, however, are exceptional. As a rule, very fat persons do not have children, and, as I have said before, the sexual function is almost in abeyance.

It has been noted that sometimes a person will suddenly become very lean indeed after enjoying quite an ordinary development of subcutaneous fat, without any departure from ordinary good health. To get lean as you get old is generally considered rather a good sign, and not to accumulate fat as you get old is generally considered a happy augury as regards long life.

In reference to some of the extreme instances of living skeletons, some exemplify diseases of muscles. We all know that the muscles waste in nervous diseases and diseases of the spinal cord, and this wasting occurs in connection with well-understood causes. But here it is different; the cause is ill understood, as in the persons with a tendency to fatten. In connection with living skeletons I now mention a few cases which correspond with those of congenital lipomatosis in which the infant becomes very fat; that is to say, those in which the infant becomes very lean. First I must tell you it is a very much rarer condition. I have two very remarkable cases in my

mind: they were both attended with dwarfing. In both the sexual system remained quite in abeyance; the testes were extremely small—the size of a hazel-nut. The voice in both remained infantile although they had attained nearly adult age. One of these patients is still living. They were both males. In one of them the mammary gland was quite absent; there was no nipple. In both the tendency to leanness was such that you could not appreciate any subcutaneous fat in any part of the body. The skin was drawn tightly over all the muscles, whose contour, as well as that of the subcutaneous bones, was visible. The outline of the biceps along its whole length could easily be traced; the muscles themselves were of a very fair size. In both hair was entirely absent—the appendages as well as the subcutaneous hair. In the case I best remember there was a peculiar hereditary history; the scalp was drawn tightly over the whole of the skull (there was a little down but no hair on the head). Now the mother of this boy had not a hair on her head; she was stout, almost fat, with large mammary glands. She was not born hairless, but lost it in childhood. She had four or five daughters, all with excellent heads of hair, and well developed in every way. But her youngest child and only son was quite hairless.

In the case which died a post-mortem was made, but nothing was found which gave any cause as to the absence of the normal adipose tissue. The clavicle, which I have in my possession, is extremely small and slender for one who has reached almost the age of an adult; it was like that of a little animal, and not so thick as a cedar pencil. Of course there must be some definite cause for this arrest of development. In the one case, there was some family history, and there may have been an hereditary tendency; but in the other, no history could be obtained.

As regards treatment there is very little to be said, and I think I have in passing mentioned the chief points. Liquor potassæ was used by our grandfathers, but we have lost our confidence to a great extent in its use. There is the question of diet. A fat person must abstain from fatty materials; this is of extreme importance. Underdone beefsteaks and hot water as a treatment of obesity is well known and very efficacious. Many systems of diet have been devised for corpulency. But diet has little effect, if any, on the cases where there is great excess of fat. Thyroid extract may be tried cautiously; it will probably reduce the patient's strength out of all proportion to the benefit derived. Surgery is of no avail.

## SUBMUCOUS MYOMECTOMY BY HYSTEROTOMY OR CÆSAREAN SECTION, NOT HYSTERECTOMY. (a)

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THE mode in which the myoma of uterus to which I direct your attention was removed is one which is not very often adopted, and it so happens that I have not used it before. The myoma filled the whole of the uterus, and by opening the uterus, very much as is done in Cæsarean section, or by hysterotomy, as distinguished from hysterectomy, it was possible to remove the tumour; and that was done with a successful result.

*History.*—Patient was an unmarried milliner, æt. 35, whom I saw in September, 1901, along with Dr. Moorhead, of Tong, for retention of urine. The urethral passage seemed elongated and tortuous, and it was a little difficult to enter the catheter. The point of the glass catheter had to be pushed about two inches upwards in the direction of the umbilicus, the opposite end being correspondingly depressed be-

tween the thighs before the bright amber-coloured natural urine flowed. About a pint was removed on that occasion, one or two drops of blood being visible at the end of the process of emptying. Patient's account was that the inability to empty the bladder had occurred on several previous occasions; as long ago as the previous May, and always, so she said, at the catamenial period. The periods were said also to have been too profuse. The condition was somewhat unusual, but having succeeded in overcoming the tortuosity and elongation of the urethra, and having emptied the bladder, I did not think much more about the condition and made no further examination. However, the next evening, on being again sent for on account of the recurrence of a similar state of things, and after again emptying the bladder, and finding that it contained no more than, say, ten or twelve ounces of urine, while there still seemed some swelling remaining, we prosecuted our inquiries further. There then seemed to be firm resistance offered to the hand pressed against the hypogastric region, and on passing the finger per vaginam a tumour was found to be projecting from the os. It was round and smooth, and was accompanied with "development" of the cervix, *i.e.*, there seemed to be little or no cervix discoverable, and the os was patent to the extent of quite an inch in diameter in every direction. Patient said that her periods used to be more profuse than of late, though they were still more profuse than natural, and seemed also to occur too often.

Patient was recommended to become I.P. in the Royal Infirmary in order to have the tumour removed, and Dr. Moorhead and myself thought that it might be possible, by separating the os from the tumour, to seize it by vulsellum forceps and by pulling and clearing with the fingers, perhaps to get it away by that means. It seemed to be, and as the event showed it was, an intra-uterine mass lying inside the mucous covering of the uterus. How extensive it was could not then be determined, but a somewhat large polypus in the act of being extruded from the uterine cavity was the impression conveyed to our minds on examination, which might, perhaps, be dealt with by expediting and hastening its extrusion. If this method of removal should prove impracticable, then further proceedings would be necessary; and hysterectomy seemed to be a possible necessity. Patient was the only support of her aged and feeble parents, who, however, after much anxiety agreed with herself as to our suggestions offering the only possible chance of relief in the circumstances. Accordingly she came in on September 12th, and on the 15th, in the lithotomy position, under ether, the finger was passed through the cervix, and the fibroid cleared from the uterine wall by finger and blunt instruments. The cervix was divided anteriorly and posteriorly for about an inch in order to aid in this process and to gain room. The growth, however, proved to be too large for removal by this means. The question then was, what was to be done. I had promised Dr. Moorhead that if further proceedings should prove to be necessary, and especially if hysterectomy should have to be performed, I should give him notice, and the opportunity of being present. However, the operation had so far proceeded to a considerable extent. A certain amount of laceration had taken place, and although aseptic precautions had been observed as far as possible, and further douching could be done, still it did not seem safe to leave a lacerated wound present in the uterine cavity, and the tumour partially torn from its attachments capable of setting up sepsis in the wound. For these reasons therefore, and as I was further urged

(a) Paper read before the Bradford Medico-Chirurgical Society, November 18th, 1901.



to this course by the house surgeon, Mr. Phillips, who gave me very efficient assistance throughout the case, I proceeded to open the abdomen and to complete the operation then and there. On examining from the interior of the abdomen the whole uterine outline was enlarged and appeared like a uterus, which retained its shape, although on an enlarged or magnified scale. It seemed evident that the tumour-mass filled the whole of the uterine cavity, and that the tumour was throughout a sub-mucous one. This being so, two courses offered themselves for adoption, one, the usual one, to remove the uterus and tumour—to perform hysterectomy, in fact; the other to open the uterine cavity, to clear the attachments of the tumour from the interior, and to remove the tumour, leaving the uterus, should that appear or prove possible. Obviously if the latter course could be adopted it would be better for the patient to have the uterus in its place than to perform hysterectomy. Accordingly, I fixed a clamp on the broad ligament on each side so as to prevent hæmorrhage. I do not know if this was a necessary proceeding, for there was no hæmorrhage. This may have been due to the pressure of the clamps, but I doubt it, because no vessels required to be tied after the clamps were removed; bringing out edge to cut edge being quite sufficient to stay all bleeding. However, the clamping was a safe precautionary measure, if not pressed so tightly as to strangulate the broad ligament structures. An incision was then made in the anterior uterine wall high up towards the fundus; this was carried right through the fundus to the posterior wall, which was also divided for about two inches. The tumour was then cleared from the interior of the uterus, its attachments being torn through, and the contents of the cavity being removed just as in Cæsarean section. The edges of the wound in anterior and posterior walls and through fundus were then brought together by catgut sutures, which passed through the serous and muscular coats, but not through the mucous coat, and the clamps were removed. No hæmorrhage, and no vessels tied. The abdomen was sponged dry and clean, and the wound closed in the usual way. Patient's recovery was quite uneventful, which was a great relief to my mind, the temperature never rising above 99.8° the day after the operation, nor the pulse above 104 the same day. Patient's temperature was subnormal when she left the hospital on October 12th, and had been so for about a fortnight. The causes of this open up a very interesting inquiry which I will not enter on now, further than to say that I have no doubt that the causes which led to the tumour-growth are the same as those which made the temperature too low, and that no doubt patient's temperature had been, like that of the vast majority of patients who suffer from chronic disease, subnormal for a long time, probably for years before I saw her.

The myoma measured 5½ inches by 4½ inches, and seems to consist of a myomatous tissue embedded in meshes of fibrous tissue.

*Remarks on the Operation.*—I do not know if the operation just described has been performed before. I have not done it, having in other cases either performed vaginal enucleation or hysterectomy, vaginal or abdominal. All that I find in Baldy on the subject are these few remarks, which as they do not unduly lengthen my paper, I shall quote: "A. Martin has connected his name with the operation of enucleation of interstitial fibroids by the abdomen." (My case is a submucoid fibroid, not an interstitial one.—A. R.) "He removes the tumour in a bloodless way by using a temporary elastic ligature, and depends upon his sutures to permanently

control bleeding. He reports sixteen cases, the uterine cavity opened in ten, and five deaths. It does not appear that anything is gained by this operation, and the mortality is high." Evidently Baldy does not like this mode of procedure.

## French Clinical Lecture.

### THE DIFFERENTIAL DIAGNOSIS

OF

### EPITHELIOMA AND SYPHILIS OF THE FACE.

By DR. DU CASTEL,

Surgeon to the St. Louis Hospital.

[SPECIALLY TRANSLATED FOR THE MEDICAL PRESS AND CIRCULAR.]

A FORTNIGHT ago a strong, robust woman came to us with an ulcer of two years' standing on the tip of the nose which had been diagnosed to be of a cancerous nature by several surgeons. This lesion had run a gradual course until the tip of the nose had little by little disappeared under the influence of the ulcerative process.

Her condition was as follows:—The tip of the nose was destroyed, and the small sore which apparently existed there was covered with a thick, dark, and adherent scab, the neighbouring skin being infiltrated, swollen, thickened, and of a dark red colour. The redness and tumefaction extended to some distance from the scab, and then gradually merged into the healthy integument. There was no other lesion on the rest of the face. None of the glands into which the regional lymphatics emptied were enlarged.

I removed the scab in order to ascertain the appearance of the subjacent ulceration, a slight discharge of a dark brown blood took place, the bleeding ceasing on the application of slight pressure.

The ulcer was fairly regular in shape, it measured about 2 cm. across, and the centre was at a lower level than the edges, which gave it a cup-shaped appearance. The surface was of a greyish-red colour, and was smooth. At the circumference the ulceration ceased abruptly, and was surrounded by the infiltrated and thickened skin just described; there was no appreciable difference of level at the line of demarcation between the ulcer and the non-ulcerous skin, no prominent limiting irregular granulating border as in epithelioma; neither had the surface the granular and blood-stained appearance which is characteristic of epithelioma, nor its tendency to "bud." It occurred to me that the ulcer presented the appearance of a syphilitic lesion rather than that of epithelioma. Moreover, on carefully examining the rest of the face, no trace could be seen of the slightly projecting brownish stains of a dirty appearance, which constitute the so-called seborrhœic or senile wart, and which is so frequently met in subjects suffering from epithelioma of the face.

On questioning the patient we failed to elicit from her any history pointing to syphilitic infection. She stoutly denied having had a chancre or previous syphilitic eruption, and her denials were apparently made in good faith. She had never had a miscarriage, indeed she had never been pregnant. We could not therefore favour the idea of syphilis of gravid origin, a variety of the disease which may well be unknown to patients. The surface of the body bore neither stains nor scars nor exostoses of venereal origin.

On examining the mouth the aspect of the case changed completely. There was a small perforation of the hard palate establishing a communication between the buccal cavity and the nasal fossæ, which did not, however, give rise to any disturbance of

function. The uvula had been destroyed; the hinder margin of the soft palate had been eroded by an ulcerative process, and was converted into cicatricial tissue adherent externally to the posterior wall of the pharynx. I had no longer the slightest doubt that we were in the presence of grave and incontestible syphilitic lesions of the pharynx. The diagnosis of the syphilitic nature of the lesion of the nose was thus confirmed. Anti-syphilitic treatment was ordered (weekly injections of calomel and the administration of 4 grammes of iodide daily). Immediately after the first injection a rapid improvement set in; the zone of inflammatory infiltration which surrounded the crust subsided and grew paler, and the ulceration appeared to be contracting beneath the crust, the edges of which gradually became loose. On the eighth day a second injection of calomel was given. The patient has now been under treatment for a fortnight; the scab has fallen off; the ulceration, as you see, has healed, and is replaced by a smooth and slightly depressed cicatrix. In presence of the results so promptly obtained under the influence of the iodo-mercurial treatment, no one can hesitate to admit that it is a syphilitic and not a cancerous lesion.

It may appear strange to you that cancer of the face can be confounded with a syphilitic lesion. This confusion, however, has occurred more than once. The nose is not the region in which the mistake usually occurs, but usually in cancer of the chin and lips. As a general rule it is the syphilitic lesion which is mistaken for cancer; it is much rarer for cancer to be mistaken for a syphilitic lesion, though this is not impossible, as I will prove to you later.

The syphilitic lesions which are confounded with a malignant tumour are primary chancre or gumma. Chancre on the lips, and even more frequently on the lower part of the face, and particularly on the chin, may attain a considerable size, so much so as to constitute a genuine tumour the size of a small apple. These "chancre-tumours" were sometimes removed by surgeons, at an epoch when their nature was not so clearly established as it is at the present day, and before the danger of mistaking them for cancerous growths had been pointed out.

The diagnosis is easy for one who has been warned. The chancre, in spite of its size, has a central cup-like depression, a smooth even surface, covered with diphtheroid exudation, and presents a grey central slough, surrounded by a red zone, from which oozes a dark sero-sanguineous fluid when the crust is removed, and this oozing, which has a very characteristic appearance, is one of the most trustworthy symptoms of syphilitic chancre. The chancre, moreover, is a lesion which generally runs a more rapid course than epithelioma, and if it be not too hastily removed, cutaneous eruptions, which also invade the mucous membranes, assist us in arriving at a diagnosis.

The gummatous lesions very often puzzle the practitioner, especially when they occur on the lips. They may appear in the form of isolated gummata, or gummatous infiltrations "in sheets." The latter are, perhaps, even more liable than the former to be confused with epithelioma, especially when they occur on the lips. When we are able to follow the evolution of the lesions from their starting point it is easy enough to recognise the gumma; we find a nodule commencing at a greater or lesser depth, forcing its way gradually towards the surface. It points, breaks down and ultimately ruptures, giving exit to a core, paving the way to an ulceration which persists for a more or less protracted period. Under these circumstances no error of diagnosis is possible. The difficulty arises when the case first comes under

observation after ulceration has taken place in a patient who is unable to give a satisfactory history. We may have to deal with a patient who does not know what syphilis is, a state of affairs much less uncommon than one might imagine, especially in women.

In spite of the resemblance which these lesions present at first sight, syphilitic and gummatous lesions and epithelioma present certain characteristic features which render it possible always to form a diagnosis after close examination.

The gummatous ulceration is surrounded by a deep red inflammatory zone, of a coppery or lean-ham colour, which becomes progressively less marked as we get further from the ulceration, but which only completely disappears at a certain distance therefrom.

The edges of the lesion are usually prominent; the border is usually swollen; moreover, the margins of this swelling are not well-defined and do not stand out in a prominent manner from the healthy tissues, and they pass into the adjacent tissues in a gentle and often very gradual slope.

The syphilitic gummatous ulceration often assumes a crater-like form with abrupt margins; in rarer cases it may burrow beneath the edges, especially in recently ruptured gummata. Sometimes it occurs in the form of a more or less extensive ulceration, hemmed in on all or part of the circumference by slight, soft swelling. The ulcerated surface may be irregular, covered with innumerable projections and depressions; the centre is generally the most depressed part of the ulcer, and from the centre the ulcerated surface rises to the level of the healthy skin by a gentle slope; the wound has a tendency to assume a cup-like shape, which is well marked in the majority of syphilitic ulcerations.

The diseased surface is generally smooth or covered with large granulations, which are slightly moist; it is of a dull-red or greyish colour; sometimes it is wholly or partly covered by a diphtheroid exudation; it bleeds easily, and the sanguineous discharge is of a dark colour, and is stopped by slight compression. The base of the ulcer is rather hard to the touch, and the glands of the affected region are usually intact.

Several of the characteristics which I have just enumerated are either absent or much modified in epithelioma.

The skin which surrounds an epitheliomatous ulceration is generally normal in appearance, neither infiltrated nor thickened; it is not surrounded by the erythematous zone usually observed round a syphilitic ulceration. A thickened projecting margin circumvents the lesion, the prominence whereof varies with the size of the lesion. If the ulceration be small and due to a superficial epithelioma, then a projecting bordering ring of about 1 mm. wide may be seen around it. This border is of a finely granular nature, composed of a series of little nodules in close contact; this may completely surround the ulcer, circumscribing the whole of the periphery, or it may be interrupted at various points, and only be met with at certain points thereof.

In epithelioma of a more serious nature the bordering ring acquires much larger dimensions; it may measure a centimetre or more across; it ceases abruptly on its external side, and the passage into the healthy skin is without transition; it is markedly projecting, and does not offer a progressive diminution like the syphilitic border; it generally has a more or less granular aspect, at any rate in its internal half. The ulceration sometimes forms a depression which is more or less cup-shaped; it is usually irregular, and is composed of a series of projections and depressions having no regular or fixed shape. The tissue is granular, formed by fine nodules, and is of a red or yellowish colour; it bleed

easily, the blood is red, and the hæmorrhage is copious and is arrested with difficulty, indeed this hæmorrhage may become dangerous.

In epithelioma the lymphatic glands of the corresponding region are almost always enlarged. The base of the tumour is often so hard as to render it difficult to distinguish from that which occurs at the base of gummata.

There is one variety of epithelioma which may easily be mistaken by one who has not previously observed it, and which is frequently mistaken for a syphilitic lesion. This variety of epithelioma generally occurs in the middle of the lower lip. It does not begin as a tumour, but commences as a small infiltration, a superficial thickening of the mucous and sub-mucous membrane, and is distinctly rounded in shape and of a greyish colour, having somewhat the diphtheroid aspect of the chancre; the surface is smooth and the affection is not painful.

In spite of the analogy which it presents to the syphilitic chancre, this lesion has certain peculiarities which enable it to be distinguished. The chancre, in the course of a month or so, begins to heal. Nothing of the kind is observed in epithelioma, in which there is no tendency towards repair. Slowly, but surely, it continues to spread. The white membrane which covers the cancerous ulcer is much more adherent than the diphtheroid exudation of the chancre. In the neighbourhood there is usually very marked leucoplasia. A very important characteristic has been brought to light by M. Darier, viz.: If we take the little diseased patch and press it between the fingers there exudes from the whole of the surface yellowish filaments, very similar in appearance to little thread worms, to the filaments obtained by the compression of the comedones of acne. These concretions have received the name of "vermiformes"; they are composed of horny cells and epidermic globes, and are of considerable importance from a diagnostic point of view. Histological examination shows that these tumours belong to the class of tubular pavement epithelioma. In spite of their trivial appearance at first sight they are of a malignant nature. Beware, therefore, of white rounded patches of some standing which develop on the middle of the lower lip.

When we are in doubt whether a lesion is or is not of a syphilitic nature, it is customary to put the patient under an anti-syphilitic treatment, and we base our judgment on the result obtained. When this has to be done to confirm a doubtful diagnosis of epithelioma, we must be careful, because the mercurial treatment has, more than once, seemed to aggravate cancers of the mouth; consequently, until lately, it was deprecated by many practitioners whenever there was a suspicion of epithelioma.

Professor Fournier has called attention to a very interesting phenomenon, viz., when in a doubtful case the patient is put under the mercurial treatment, not by the mouth, but by subcutaneous injections of calomel, there is usually observed to occur a diminution of the lesion during the first few weeks, whether it be syphilis or cancer. In the case of epithelioma the amelioration ceases after a certain time, the disease recommences its destructive progress, and nothing can stop it. If it be syphilis the amelioration continues until a cure takes place. The good effects of mercury do not, therefore, constitute absolute proof that we have to do with a syphilitic lesion, for we may have the same results in the case of epithelioma; but in this case they are only transitory, and after a few weeks the disease resumes its onward march. This observation has often been made on the buccal mucous membrane; it has not been clearly ascertained whether it is of as frequent occurrence on the skin of the face and lips, but this would seem to be the case.

In any case, when you try the anti-syphilitic treatment and observe a slight improvement in a doubtful lesion, do not cry victory too quickly; wait till the improvement increases and continues, and remember that on the tongue and in the mouth it is not rare for epitheliomas to undergo temporary diminution under the influence of mercurial injections; moreover, it is not inconceivable that the same thing should also occur on the skin.

## Clinical Records.

[REPORTED BY OUR BERLIN CORRESPONDENT.]

KAREWSKI'S KLINIK, BERLIN.

*Case of Gonorrhœal Joint Affection with Demonstrations of Gonococci in the Blood.*

Under the Care of HR. UNGER.

A YOUTH, æt. 18, hurt his hip in a swimming bath on June 1st. Acute pain settled in the spot with fever. On admission into klinik, osteomyelitis was thought of, and a puncture was made, but only pure blood came away. Then gonorrhœal coxitis became the question, and gonococci were found in the urethral secretion. The coxitis improved under a plaster-of-Paris dressing, but in a short time swelling of the elbow and wrist came on with a good deal of rise of temperature. On now examining the blood gonococci were found. At the apex of the heart a slight systolic murmur was heard, and over the aorta a slight diastolic murmur. In examining the blood 10 ccm. were taken from the median vein, and development of gonococci took place when placed in ascetic fluid, whilst cultures on the wound remained sterile. The speaker attributed the negative results usually recorded to be due not to any killing off of the gonococci by high temperatures, but to improper methods of investigation. A proper method required, first, a large quantity of blood, as the gonococci were not numerous; secondly, dilution with a large quantity of nutrient fluid, whereby the bactericide action of the blood serum was weakened; and thirdly, a fluid nutrient medium as this aided the development of the cocci the same as in typhoid.

HR. Max Michaelis thought Unger's observation of great interest. He quite agreed with his method of investigation. By means of it he himself had proved the presence of streptococci and staphylococci in the blood in tuberculous cases.

Dr. Klemperer had published an interesting case of spread of gonococci by the blood tracts in the case of an infant with blenorrhœa. Multiple inflammation of joints soon followed the blenorrhœa, which, however, quickly receded. Then an abscess developed in the back, and on being opened a large quantity of gonococci were found in the pus, as many as were found in the blenorrhœic discharge. Local external transportation from the eye to the back was out of the question, the cocci must, therefore, have got there through the blood track. Fränkel had, moreover, always found pneumococci in the blood in pneumonia, even after the crisis. He also advocated the use of large quantities of blood and large quantities of nutrient soil to reduce the bactericide action of the blood serum. Gonorrhœal joint affections were comparatively frequent. They were generally monoarticular, and were characterised by a doughy swelling around the joint from participation on the part of the periarticular tissues. Such inflammations were frequently and wrongly considered to be rheumatic.

HR. Unger further said that as the gonococci disappeared from the blood very rapidly, examinations were often made too late. Examination should always be made within twenty-four hours of the first appearance of the swelling. The joint affections were caused by the gonococci themselves and not by their toxins, as the fluid containing them, after they had been filtered out, set up no infection in animals.

## Transactions of Societies.

### OBSTETRICAL SOCIETY OF LONDON.

MEETING HELD DECEMBER 4TH, 1901.

Dr. PETER HORROCKS, President, in the Chair.

#### SPECIMENS.

##### RUPTURED TUBAL GESTATION.

DR. AMAND ROUTH showed a specimen of ruptured gravid Fallopian tube; the rupture having apparently taken place while tubal abortion was also in progress, or possibly soon afterwards. The patient, *æt.* 27, had been married three years, and had had one pregnancy, followed by abortion. In the beginning of September, 1901, she had a normal period; at the end of the same month, and several times in the course of October she had a slight irregular show, and early in November she had an attack of syncope. The doctor who saw her diagnosed colic, and gave her an opiate. Her condition continued very unsatisfactory, and Dr. Routh was asked to see her. She had then just had a second serious attack of syncope, and appeared to be almost dying. He proceeded at once to operate and found a quantity of free blood in the peritoneal cavity. The left tube presented in the wound, and was found to be the seat of a rupture from which hæmorrhage was going on. From the open fimbriated end of the tube bleeding was also taking place. The fœtus had passed out of the tube, and was lying, with cord and placenta attached, in the abdominal cavity. The operation presented no special difficulty, but just before the abdomen was closed some fresh bleeding took place from a vein at the back of the broad ligament, and at that moment the anaesthetist found that the chloroform had run out. Dr. Routh consequently applied two clamps on the broad ligament, one at the uterine end and one near the pelvic wall; and the hæmorrhage fortunately ceased at once. The clamps were left on, gauze was packed round them, and the abdomen was closed, leaving the clamps and gauze projecting. The clamps were removed on the second day, and the gauze on the fourth. The patient happily did well, the recovery being assisted by saline transfusion.

Dr. C. J. CULLINGWORTH said that the case presented many features of interest from the clinical point of view. From the pathological standpoint the chief interest in the case consisted in the co-incidence of tubal rupture with hæmorrhage going on through an open fimbriated extremity, so that a double hæmorrhage took place. One would have expected that the fact that the abdominal ostium was patent would have been sufficient to insure against rupture of the tube, especially in former days when it was taught that the tube ruptured because it could not expand sufficiently to accommodate the growing ovum. Late teaching was to the effect that rupture was due to sudden expansion of the tube by hæmorrhage; for it had been shown that the walls of the tube could expand almost indefinitely provided that the distension was gradual. More recently the view had been propounded in Germany that rupture was brought about by infiltration and consequent thinning of the wall of the tube by the chorionic villi, and this would readily account for the condition found in Dr. Routh's case.

Mr. J. H. TARGETT remarked that the wall of the tube in this case presented a very marked degree of thinning, and he had no doubt that this was the result of infiltration by the chorionic villi.

Dr. HUBERT ROBERTS recalled the fact that the thinning of the tubes in cases of extra-uterine gestation had been specially insisted upon by Mr. J. W. Taylor in his Ingleby Lectures.

##### DOUBTFUL SEX.

Dr. W. S. A. GRIFFITH showed a person of uncertain sex, *æt.* 26. The individual was considered to be of the male sex, but undeveloped. He had no beard, the voice was feminine, and there was a large amount of fat over the pubes. On the other hand, there was no development of the breasts and there was no vagina. The penis

was very small, but was perforated terminally by the urethra. A small scrotum was present, but it was uncertain whether or not it contained a rudimentary gland on one side.

Dr. HUBERT ROBERTS showed the internal and external generative organs of a male pseudo-hermaphrodite, the specimen belonging to the museum of St. Bartholomew's Hospital. The male sex had been determined by microscopic examination of the genital glands, which proved to be testicles. There was a fairly well-developed uterus.

Dr. G. F. BLACKER expressed the opinion that Dr. Griffith's case was an undeveloped man; the secondary sexual characters were of comparatively little importance in such cases. If a gland were down in the scrotum, it was nearly always a testicle, and the cord, if it could be felt, was conclusive evidence. He drew attention to some recent investigations on the differential ossification of the thyroid cartilage as a means of diagnosis of sex, and suggested that Dr. Griffith should obtain an X-ray examination of the patient to elucidate this point.

##### FETAL DEFORMITY.

Dr. STANNUS (introduced by Dr. W. W. H. Tate) showed a specimen of a fœtus with a curious deformity of the face. The specimen was referred to the Teratological Committee for report.

A short paper was read by Dr. MAXWELL on vomiting in pregnancy, with reports of two cases in which labour was induced.

Dr. CUTBERT LOCKYER showed two septicæmic uteri, removed post mortem, in each of which staphylococci were found in the uterine muscle deep to the placental site. In the first case the patient lived for fifty-one days after premature delivery of twins at the sixth month. Labour and the first eighteen days of the puerperium were normal and afebrile; on the nineteenth day violent bleeding set in and the doctor removed a piece of adherent placenta by the finger. Rigors followed, and the accoucheur cured; this operation was twice repeated. Removal of the uterus was out of the question, as a membranous inflammation extended from the fundus uteri to the vulva. Serum therapy and saline injection were of no avail, and the patient died of pulmonary infarction fifty-one days after delivery and thirty one days after infection. The specimen showed general thrombosis of the right pampiniform plexus with an abscess around the ovarian vessels; the right ovary was normal, and there was no peritonitis. At the time of death the uterus and vagina were clean and death was due to the lung condition. The organisms present were proved by cultures, guinea-pig inoculation and staining to be staphylococcus pyogenes albus. In the second case the patient lived for ten days after delivery, which was normal and unaided; there was no involution of the uterus, the cavity of which was sloughing from fundus to internal os. General peritonitis set in on the third day, and at the autopsy the entire peritoneum was covered with purulent flasky lymph. There was no infective thrombosis of the uterine vessels. The lungs were œdematous, but there were no infarcts. The uterine muscle showed the presence of groups of cocci, some in zoogloea masses, others in the typical staphylo arrangement.

Observations were made on the specimen by Dr. Drummond Robinson, Dr. Horrocks, and Dr. Routh.

A paper was read by Mr. R. SANDERSON, M.B., Oxon. (Brighton), on

##### VAGINO-ABDOMINAL HYSTERECTOMY

in a case of pregnancy of four and a-half months, complicated by epithelioma of the cervix uteri. The author reported a case of epithelioma of the cervix in a uterus that was four and a-half months pregnant. Finding that the epithelioma was operable, he removed the uterus and the growth by a combined vaginal and abdominal operation, without previous induction of labour. The specimen and microscopic section of the growth were described and shown. The ethics and the treatment adopted were discussed under the following heads. (1) That where pregnancy and operable cancer of the cervix co-existed the life of the mother alone

was to be considered. (2) That anterior to the fourth month of pregnancy vaginal hysterectomy was the orthodox treatment. (3) That after this period the alternative methods were (a) induction of labour followed by vaginal hysterectomy; and (b) hysterectomy, without induction of labour, by a combined vaginal and abdominal operation. (4) That the latter of these alternatives, having regard to the improved statistics of abdominal hysterectomy, was in this case to be preferred.

The paper was discussed by Dr. Griffith, Dr. Tate, Dr. Routh, Dr. Dauber, and Dr. Spencer.

ROYAL ACADEMY OF MEDICINE IN IRELAND.  
SECTION OF PATHOLOGY.  
MEETING HELD FRIDAY, NOV. 29TH, 1901.

E. J. McWEENEY, M.D., President in the Chair.

DR. PARSONS read notes on a case of  
GASTRECTASIS.

The patient was admitted into the Royal City of Dublin Hospital complaining of a continuous severe burning pain in the stomach. He vomited frequently a clear, watery fluid without trace of blood. The vomiting always occurred after food. This condition had existed for two months, during which time the patient became thinner and weaker. For the first two days in hospital the patient did not vomit, but he belched wind freely. On the third day he vomited three pints of a clear fluid; on the fifth day two pints. In three days he vomited three pints and a-half of fluid, during these three days he had taken eighteen pints of fluid, so it was concluded that some absorption had taken place. During the first week in hospital he gained seven pounds in weight, but the following week lost four pounds, showing a gain of three pounds in weight during his fourteen days in hospital. He looked phthisical, was much wasted, had a malar blush, and big ears, but on examination his chest was found to be normal. On feeling the abdomen succussion was easily obtained—in fact, actual splashing was obtainable. If he turned on one side the side other than that he was on became resonant. The case was diagnosed as gastrectasis and hour-glass constriction suspected. Vomiting freely on Sept. 5th. The first vomit measured five pints, and the second vomit on that date measured seven pints. Sept. 6th not so well. On the 7th he vomited eight pints. On the 8th he was in a state of profound collapse. He complained of pains in his arms and legs, he was cold and pulseless; gastro tetany.

Mr. Johnson now performed a gastro-enterectomy at half past four o'clock in the evening, and the same night the patient died. There was no trace of any local or general peritonitis. The stomach, from the pylorus to the fundus along the great curvature, measured thirty-one inches, by the lesser curvature thirteen inches. No fluid could be forced from the stomach into the duodenum, and it was not until it contained six pints of fluid that any leakage took place from the surgical wound. A tight stricture of the pylorus was present. A few days before the patient's death hydrochloric acid was found in the gastric juice, its presence may, however, have been due to the use of solution of strychnia, which had been prescribed for him.

DR. PARSONS does not lock upon the absence of hydrochloric acid as pathognomonic of carcinoma of the stomach, though he thinks its presence negatives the presence of the disease.

DR. McWEENEY asked what was the exact condition of the pylorus, and what diagnostic value he attached to the presence of hydrochloric acid; in what class of cases was hydrochloric acid absent, and, lastly, was a test meal given? In his experience he never found hydrochloric acid wanting in normal digestion; and he would like to hear some views on the ætiology of hour-glass constriction.

DR. TRAVERS SMITH remarked that it was unusual that such a tight pyloric stricture should occur in so short a time as two months in a malignant case, though not so much so in one of gastric ulcer. A reasonable

theory for the causation of hour-glass constriction is contraction of the central fibres, which not unusually results from post-mortem handling of the viscus.

DR. KNOTT said that he found in medical literature reference to post-mortem hour-glass contraction, but was not conscious of having met with such a condition.

In reply, DR. PARSONS said he had not given a test meal. Hydrochloric acid was absent in a case of supra-renal capsular disease that came under his care. He had no theory to explain the ætiology of hour-glass contraction.

Professor O'SULLIVAN, who made a section through the pyloric orifice of the specimen, demonstrated the presence of two gastric ulcers which had penetrated to the peritoneal coat. No carcinoma present.

DR. PARSONS also read notes of a case of

ANEURYSM OF THE AORTA.

This patient came under notice in 1897. He complained of violent paroxysms of pain in the chest, which shot down the left arm; they were preceded in every instance by a severe fit of coughing. He complained of no difficulty in swallowing. There was no history of syphilis, gonorrhœa, or rheumatic fever. His face was pale; there was carotid pulsation, well marked; capillary pulsation was present, and the radial pulses were synchronous and regular; double aortic murmur heard distinctly. After a time in hospital he greatly improved, and left feeling able to resume his occupation. On October 17th last he returned. His apex beat was found in the seventh intercostal space; the left vocal cord was immobile. He suffered from aphonia and dysphagia, and died of œdema of the lung. Aneurysm of the ascending and transverse portions of the arch of the aorta with hypertrophy of the left ventricle was found. Dr. Parsons considers that the double aortic murmur was due to the aortic dilatation producing a relative incompetency, as the aortic valves were perfectly normal, and could not be looked on as producing it. The interest of the specimen consisted in the freedom from disease of the valves and the fact that the aortic walls were diseased from their origin.

Professor O'SULLIVAN exhibited

"BLOOD FROM A CASE OF TROPICAL MALARIA SHOWING CRESCENTS."

The specimen was prepared by Professor Ewing, of the Cornell University, New York.

DR. McWEENEY considered the specimen as the finest Romanofsky staining ever exhibited in the Academy.

MR. STORY exhibited sections (made by Dr. Earl) of a

ZONULAR CATARACT,

removed from the eye of a man, æt. 40, the second eye being similarly affected. The sections showed the same appearances which have been described by Beselin, Lawford, and Schirmer in such lenses, viz., normal cortex, a nucleus studded with vacuoles, and zone of densely packed vacuoles forming the cataractous area just outside the more sparsely vacuolated nucleus. Mr. Story touched upon the various theories which have been proposed by Arlt, Horner, Schirmer, and Peters, to account for this form of cataract, its connection with dental deformities, and association with rickets, and while expressing his adhesion to the more modern form of Horner's theory as advocated by Schirmer, remarked that there was a good deal still to account for before this theory could be unhesitatingly accepted. One point was that no zonular cataract had yet been described, which was as large as the normal lens (according to Dub) in the first year of life, so that they should be all formed in utero. If so, where did the connection with the permanent teeth come in? The milk teeth are not affected in these cases so far as he knew. Again, if the whole lens existing at the time is implicated in the lesion, how is it that no observer has seen a cataract at first affecting the whole lens, that is the opacity reaching to the surface, and then gradually turning into a typical zonular cataract by the deposition of fresh transparent fibres on its exterior.

DR. McWEENEY was of opinion that this case raised many debatable points on the epiblastic theory.

Dr. EARL drew attention to the fact that the so-called cleft was not well marked in these cases, and the vacuoles might be looked on as artificial. There is a great difficulty in making sections of a lens. Schirmer thinks that glycerine gives the best results.

Dr. L. SYMES remarked that rickets are so common and zonular cataract so rare that they cannot be looked on as cause and effect; in nystagmus occurring during convulsions in childhood the oscillation is not sufficient to produce the effects credited to it, besides, nystagmus is often present without zonular cataract, and in many cases of convulsions the eyes are perfectly still. The etiology of the disease is to be sought in general debility. Mr. Story looks on nutritional defect as the source of the trouble.

Mr. H. GRAY CROLY brought forward a case of  
SARCOMA OF THE KNEE,  
for which amputation of the hip-joint was performed. Patient, a woman, *æt.* 48, who enjoyed good health until twelve months ago, when she received a kick from a cow. Soon after receiving this injury her knee became very painful and swollen, and she was unable to put her foot to the ground. She was admitted to the Royal City of Dublin Hospital under Mr. Croly's care, on October 28th last. Her knee was found to be considerably swollen, measuring several inches more in circumference than the other knee, her temperature before operation ran up in the evenings to a little above 101°. On Tuesday, the 19th inst., Mr. Croly amputated through the hip-joint. Patient doing very well. Temperature normal, and no trace of suppuration in the wound.

Dr. B. WHITE's note on the pathology of the above case:—"The tumour assumed a pyriform appearance, was situated at the lower epiphysis of the femur, the base downward, the size approached that of a medium-sized melon, and gave the idea on palpation of an india-rubber ball well distended with fluid, the appearance of the skin was mottled from staining round the veins. On cutting open the structures there was disclosed a greenish-white tissue, rather firm and elastic, and dotted over with vascular points, and one or two blood cysts. A portion examined under the microscope showed it to correspond to the structure of sarcoma, consisting of cells chiefly spindle in shape. Scanty in the cellular substance, blood channels, or spaces formed by or between, the cells, there was no appearance of bone structure; it may be classed, therefore, from its position and structure, as a spindle-celled periosteal sarcoma."

The Section then adjourned.

#### LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD NOV. 21st, 1901.

The President, Mr. EDGAR A. BROWNE, in the Chair.

CASES were shown in the Library:—

- 1st. Mr. C. G. LEE a patient showing a typical example of persistent hyaloid artery.
- 2nd. Dr. ANDERSON, "Molluscum Fibrosum."
- 3rd. Dr. HUNT, "Hysterical Aphonia with Inspiratory Stridor."

#### HEROINE HYDROCHLORATE.

Dr. MACFIE CAMPBELL said he had been in the habit of using this drug frequently in doses of 1-6 gr. but recently had an alarming experience with a 1-12 gr. dose. The patient, a lady, was given a dose (1-12 gr.) at 9 p.m., was very restless during the night, and had a second dose at 7.30 a.m., soon after which he found her livid, breathing short, oppressed pulse, contracted pupils, with a sense of impending death. Strong coffee was administered, and she was all right at night.

It is noticeable that in the new edition of Martindale the dose is grain 1.25—1.12, and caution in its use is necessary. It is most useful in laryngeal cough.

Dr. A. C. RENDLE read notes of a case of

#### EMPYEMA AND ASCITES

associated with cirrhosis of the liver. The patient, a man, *æt.* 33, with a history of being a heavy drinker, was seen in January, 1900, complaining of acute pain

over the liver, which was tender and was felt two inches below the costal margin. There was jaundice, and the urine was loaded with lithates. Treated with salicylate of soda the symptoms subsided in a week. Six weeks later he had a second attack, and soon afterwards developed a lobar pleuro-pneumonia, the temperature reaching 105°, accompanied by active delirium and desferescence by lysis, temperature being normal on the twelfth day. Ten days later there was well marked right-sided empyema, treated by resection of rib and evacuation of pus. Five days later fluid was collecting in the peritoneum, and subsequently the patient was tapped three times at intervals of one and two weeks, the amount of fluid at each tapping being from two and a-half to three gallons. The nature of the obstruction in the liver was probably two-fold, alcoholic and syphilitic. The recovery was uninterrupted after the last tapping, and the patient has been at his work for the last twelve months.

Dr. W. CARTER had seen a dozen cases of ascites recover, and related the case of a lady who had been tapped regularly many times at intervals of three weeks; an attack of pleurisy led to the application of a 10 c.c. preparation of oleate of mercury in oleic acid, which by mistake was applied all over the abdomen, resulting in an acute erythema, and prolonging the interval of tapping to six weeks, after which the patient recovered and remains well now, four years later. If, after tapping, the urine increased in quantity, there was a better prognosis; if, on the other hand, the quantity of urine diminished, it was quite certain there would be no improvement.

Sir WILLIAM BANKS showed a lad of sixteen who had been accidentally shot with a pea rifle, which went off at a distance of two feet from the patient's face, entering the skull just at the root of the nose, slightly to the right of the middle line. Insensibility followed which lasted a week. On recovery there was complete paralysis of the left arm and leg and partial paralysis in the face. Six weeks later the face had recovered and power partially returned to the arm and leg. He could close the fingers with a good, strong grasp, but he could not open them again except with the help of the other hand. An X-ray photograph showed the bullet in the cerebrum about an inch and a half in front of the skull and about one inch to the right of the middle. Small black specks at the point of entrance of the bullet into the skull showed where fragments of lead had been knocked off its surface; it had thus traversed the whole of the cerebrum from front to back.

#### VOMITING A GALL-STONE.

Mr. S. KELLET SMITH and Dr. FRANCIS BAILEY reported a case in which a small gall-stone was vomited. The patient was an old lady, *æt.* 60, who had had three previous attacks of biliary colic—paroxysmal recurring pain, extreme tenderness over the liver region, incessant vomiting, eructations, and hiccough, and deep jaundice. At no time was the gall-bladder enlarged, and in none of the attacks was any gall-stone found in the faeces, nor was anything discovered at all suggestive of a membranous cholecystitis. In January, 1900, she had another attack of colic, and shortly after its onset vomited a small gall-stone. The symptoms subsided almost as suddenly as they had commenced, and the patient has been well ever since. The vomited stone is a small, light brown stone, regularly pyramidal in shape, and weighs 5 grs.

Dr. BAILEY corroborated Mr. Smith's history of the case, and pointed out the rarity of the condition, and comparing it with the records of cases of passage of the stone per rectum and through an abdominal sinus. The stone probably passed *via* the duct into the duodenum and thence by a retroperistaltic wave into the stomach.

Dr. CROOKE also reported a case of vomited gall-stone; a woman, *æt.* 40, had an attack of biliary colic, and developed acute intestinal obstruction, probably in the duodenum. She vomited a small gall-stone weighing 13 grs., and two days later the obstruction gave way, and she afterwards passed a large gall-stone, weighing 198 grs. Seven other stones were subsequently passed.

The gall-stone probably ulcerated from the gall bladder into the duodenum. There was never any jaundice.

Mr. PAUL said it was rare for gall-stones to be vomited. He had met with cases in which gall-stones were discharged through an abscess opening on the surface, also where they had ulcerated into the duodenum, and in many cases he had found adhesions between the gall-bladder and the stomach, the duodenum and colon. He agreed that in the present cases the stones passed into the stomach through the pylorus, and as regards the size of the latter orifice measurements were not to be taken as having much bearing upon the point, in view of the fact that tooth-plates, large knives, &c. frequently passed the valve with apparent ease.

Dr. R. J. M. BUCHANAN read notes of two cases. (1) Primary hydatid cyst in the right lung. The patient was an Australian, and had suffered from the condition a long time. The contents of the cyst were expectorated during paroxysms of coughing. Radiographs of the thorax taken by Dr. Holland showed the cyst in position, and it was easily recognised on examination with the fluorescent screen. (2) Pneumothorax occurring during muscular strain in a healthy male. The lesion was in the left lung. No effusion of serous fluid took place, and the condition gave rise to but slight inconvenience to the patient. Fixation of the chest with strapping, and absolute rest for three weeks, resulted in complete absorption of the air and expansion of the lung. Radiographs of the thorax taken by Dr. Holland were exhibited, and showed the developed lung well defined, and surrounded by a clear area. With the fluorescent screen the condition was easily recognisable.

Dr. BOUVERIE McDONALD read a note on

#### SUTURE OF THE FRACTURED PATELLA,

with Special Reference to Early Movement of the Knee-joint. He referred to the numerous methods devised for the treatment of the transverse fracture of the patella. Good results undoubtedly followed the employment of simple retentive apparatus in many cases; functional usefulness sufficient for the well-to-do patient, and even bony union was reported to have taken place, but in a large proportion of cases the limb was permanently weakened, and cases were reported of gangrene resulting from the bandaging and amputation, and even death from the use of hooks and pins. He pointed out, as an important factor in the prevention of coaptation, the effusion of blood separating the fractured surfaces, coagulating and forming a solid bar to any apposition by ordinary mechanical means. With antiseptic and aseptic precautions we can now, with comparative safety, open the knee joint, remove blood-clot, and overcome muscular contraction by the wire suture, and thus obtain bony union, resulting in a strong and useful limb. Suitable cases only should be selected for operation, i.e., individuals not beyond the prime of life and of healthy physique. Reference was made to the length of time (three to four months) usually taken for the treatment of such a fracture as against five weeks for the open method, and the more certain result of bony union was more favourable to the working class, who cannot afford a long and tedious confinement, and for whom it is important the limb should be strong and perfect. Great importance was attached to passive movement, which should begin at the end of the first week. A successful case was reported and radiograph shown.

Mr. RUSHTON PARKER, while allowing all that could be claimed in favour of primary wiring, especially in selected cases of persons following laborious or active employment, feared it was not widely known what excellent results, with strong and freely movable knees, could be obtained by putting up the limb rigidly straight from the first, and continuing the treatment for four or six months. The best apparatus is Thomas's calliper knee-splint, with which cases of fractured patella may be treated with confinement to bed for a few days, or even not at all. He believed the chief separator of the fragments to be flexion of the knee, and that therefore the most important item in mechanical treatment was the prevention of a single flexion of the joint until the union was strong enough to bear the usual strain. Bony union, though rarely thus occurring, was

not important nor essential in cases to which this method is applicable.

Mr. F. T. PAUL said that some years ago he sutured, by Mr. Barker's or an allied method, all the cases under his care, and although there were no failures, the results were not such as to warrant operative treatment. Hence he had returned to the use of Thomas' splint, and the method of fixing the fragments employed with it. This method was certainly long, but he was not aware of a single patient who had complained of the subsequent condition of the limb. This point was explained by the fact that an allied injury—rupture of the ligamentum patellæ—if treated without suture, gave a most unfortunate result which could not pass without notice. It was essential to suture the ligament when ruptured.

Mr. ROBERT JONES thought that wiring should be reserved for the exceptional case, and not be adopted as a routine. By efficient mechanical methods excellent results could be obtained without any risk, and the patient allowed, after the first few days, liberty to walk about. He had met with many cases where trouble had been roused by wire, after active treatment had been discontinued. He had many patients with fibrous union doing hard work at the docks.

Dr. R. J. M. Buchanan, Dr. W. B. Bell, and Messrs. Thelwall Thomas and George Hamilton discussed the case, and Dr. McDonald replied.

## THE GENERAL MEDICAL COUNCIL OF EDUCATION AND REGISTRATION.

Sir WILLIAM TURNER, K.C.B., President, in the Chair.

SIXTH DAY.—MONDAY, DECEMBER 2ND.

#### A TRIANGULAR DUEL.

The question of privilege alluded to by the President at Saturday's meeting of the Council had reference to a letter embodying what purported to be a quotation from a speech by Mr. Victor Horsley to the effect that Mr. Brown had been "shouted down" by the Council and "flouted" by the President.

The PRESIDENT, in accordance with precedent, called upon Mr. Horsley for his reply.

Mr. HORSLEY thought that the first step ought to have been to communicate to him the contents of Mr. Brown's letter, and to have asked whether the contents of Mr. McCook Weir's letter was a correct statement, because the whole question was "a squalid electioneering device." The letter in question, he observed, was "a literary forgery." He explained that in the speech from which the expressions in question purported to have been culled, he was urging the election of general practitioners to the Council who should worthily represent practitioners—persons, in fact, who would not "excite derision and contempt on the part of members of the Council." In respect of the words attributed to him he referred to the reports of his speech as evidence that he did not employ them. The letter was a falsification, not only of the words he used, but of the sense of his speech, and this was not the first time his words had been falsified by Mr. McCook Weir. In reply to the President, Mr. HORSLEY repeated that he entirely disclaimed the words and expressions in question.

Mr. BROWN explained that he had felt it incumbent upon him to take cognisance of the matter, because the conduct of the President towards himself had been called in question. He admitted that he had taken no steps to ascertain for himself whether Mr. Horsley had or had not said anything of the kind; he had no time to read Mr. Horsley's speeches, but he had been thirty years before the profession, and he was quite content to leave his professional and public character with the professional gentlemen, who could judge for themselves.

After some discussion on a point of order, the PRESIDENT said that the matter would end with the appearance on the Minutes of Mr. Horsley's reply.

#### THE PREVENTION OF PERSONATION.

The Council in committee then resumed the consideration of the provisional regulations and notices of motion approved by the Personation Committee.

Dr. BRUCE moved that the matter be referred back to the Committee, in order to obtain detailed comments from the Branch Registrars on these regulations as formulated by the Committee.

After some discussion the motion was carried.

#### SCALE OF SCHEDULED POISONS.

Dr. MACALISTER brought up the question of a notice to be issued by the Council defining the precise nature of the offence, and after some discussion on the wording it was agreed that the notice should be issued in the following form:—"Whereas it has been made to appear to the Council that certain registered medical practitioners, who keep medical halls or open shops in which scheduled poisons or preparations containing scheduled poisons are sold to the public, have been accustomed to leave in charge of such halls or shops assistants who are not legally qualified to sell scheduled poisons to the public, and that such practitioners have thereby, for their own profit and under cover of their medical qualifications, enabled such unqualified assistants to sell scheduled poisons, and so to commit breaches of the law; and whereas, in the opinion of the Council, such practices on the part of a registered medical practitioner are professionally discredit and fraught with danger to the public, the Council hereby gives notice that any registered medical practitioner who is proved to have so offended is liable to be judged guilty of infamous conduct in a professional respect, and to have his name erased from the *Medical Register*, under Section 29 of the Medical Act, 1858."

#### EDUCATION COMMITTEE'S REPORT.

After a futile attempt to shelve the report for this session, Sir JOHN BATTY TUKE said the suggestions of Mr. Ball and Dr. Bruce had been carefully considered by the Committee, but they had been unable to come to any agreement on the subject allowing of a proper report, so he merely placed before Council a statement of the general principles involved in those suggestions. His feelings did not allow of his moving the first item himself, and he therefore passed it on to—

Sir CHRISTOPHER NIXON, who asked the Council to affirm the principle that it would be desirable to establish a preliminary scientific examination, that it was desirable to postpone the registration of students until the preliminary scientific examinations had been passed, and that the period for the medical curriculum for the date of registration should be four years, devoted to strictly medical study. He proposed to discuss the points that he had mentioned in a purely academic form so as to elicit from the Council its opinion whether it would be desirable to make what seemed a very radical change in their system of education. He, therefore, moved the adoption of the first item in the statement which embodied these suggestions. He wished to distinguish between the conditions with regard to the preliminary subjects and the length of the medical curriculum after registration from the question as to where the preliminary scientific subjects should be studied. He pointed out that the subjects of the first year of medical education were not medical subjects at all, but were put down only to ensure a certain amount of general culture on the part of students. There was greater reason to introduce a preliminary scientific examination now that the ordinary course had been prolonged to five years. The question as to what institutions ought to be recognised, he thought, concerned more the licensing corporations than the universities, and he did not see why these institutions should not be put on the same footing as the University of London, which required no specific course of lectures to be attended. With regard to the points in dispute between the Royal Colleges and the Council, he thought the Colleges were in the right, though he might not approve of their method of dealing with the matter. He inclined to the view that when the Council recognised certain scientific institutions, in which training in medical subjects might be given, it gave away the whole case. At the suggestion of the President the speaker modified his resolution to read as follows:—"That the Council approves of the suggestion that the

registration of medical students should be postponed until the student had passed (1) a recognised examination in arts, and (2) a recognised examination conducted by the qualifying bodies in preliminary and scientific subjects, on the understanding that the course of professional study should occupy at least four academic years."

The motion having been seconded by Dr. Bruce *pro forma*, Dr. PETTIGREW spoke against the motion, urging that it would introduce confusion.

Dr. BENNETT observed that the University of Dublin held itself free to vary the five years' curriculum in such a way as might be considered best in the interests of its students and of medical education. He was instructed to state that the proposed changes were held to operate against medical education in Ireland, and that to substitute examinations for systematic teaching would be a retrograde step. The registration of medical students was incomplete in view of the action of the Royal Colleges, and in view of that fact the University of Dublin held itself free in regard to the question of registration, and he supposed that most of the other bodies would take the same course.

Dr. BELL thought the motion, if adopted, would have for effect to place scientific subjects in the same category as subjects in general education, and would enable them to come to an agreement as to the four years' professional study. If any better way of arriving at this result could be suggested, it would have his approval and support.

Dr. PAYNE, in the course of his remarks, observed that if the Council were to adopt this resolution it should not approve of any particular method for the acquirement of scientific education, but should allow a certain amount of liberty to the student.

Dr. WINDLE said that he should vote against the resolution, which he believed would be directly contrary to what his university believed to be the best in the interest of medical education; consequently, if passed, the condition was not one which his university would observe.

Dr. MCVAIL was satisfied that none of the Scotch universities would fall in with this proposed system, the effect of which would be to wreck the whole educational machinery of the Council. The University of London did not insist upon any curriculum in the arts and science, yet no man could pass their examination unless he had been through a thoroughly good course. The proposition was framed in order to save the position of the Royal Colleges, but what, he asked, of the other universities and corporations?

Mr. HORSLEY said that this question, in one form or another, had been brought up at every meeting which he had attended throughout the country, and general practitioners were watching the matter very closely. The profession, so far as he could make out, was of one mind—viz., that the authority of the Council should be maintained, as against the Colleges.

Dr. YOUNG said his university was waiting to see what course the Council would take; in other words, they held themselves free to deal with the question of the medical curriculum in the way they thought best.

Dr. GLOVER pointed out that there was no essential difference between the arrangement proposed and that in practice at the London University. If it was right for the University to have a scientific examination, it could not be wrong for the Royal Colleges to do the same.

Mr. TICEBORNE and Dr. LITTLE spoke against the proposal, and Mr. G. BROWN pointed out that the members of the College of Surgeons were by no means in sympathy with the representatives of the Colleges on the Council. He thought that if the Council yielded on this point medical education would be materially lowered.

Sir JOHN WILLIAMS approved the carrying on of scientific education in the schools, at which such teaching would receive a great stimulus by their recognition by the Council as places where these subjects could be taught.

Dr. BRUCE endorsed the last speaker's remarks, and hoped the motion would be passed.



The motion was ultimately negatived by 17 to 10 votes, and the Council adjourned.

#### SEVENTH DAY—TUESDAY, DECEMBER 3RD, 1901.

WHEN the Minutes came up for confirmation Mr. HORSLEY challenged their accuracy in respect of his explanation on the privilege question reported in yesterday's discussions, and incidentally he protested against questions of privilege being raised on irresponsible reports of members' speeches. He repeated that he thought the contents of Mr. Brown's letter ought to have been communicated to him. Mr. Horsley's corrections were embodied in the Minutes and the matter ended.

#### RE-ELECTION OF THE PRESIDENT.

The President, having formally resigned his office as from to-day, was unanimously re-elected amid cheers, and in acknowledging the honour done to him the President assured the Council of his intention to do his duty to them and to the profession.

#### THE QUESTION OF MEDICAL EDUCATION.

Dr. McVAIL moved that a committee be appointed to report on the differences that have arisen between the Council and the Royal Colleges of London in regard to the courses and conditions of study, such report to be considered at a special meeting, when the Council should decide whether any action ought to be taken under Section 20 of the Medical Act (1858). The motion was seconded by Mr. YOUNG, who insisted on the importance of dealing with the matter without delay. He hoped that at the same time cognisance would be taken of the differences that had arisen between the Council and other licensing bodies.

Dr. GLOVER failed to see any reason for voting such an important resolution, thus superseding the Education Committee, and he suggested that the matter should be postponed for at least six months.

Dr. ATHILL objected to the proposed committee, which would entail futile expenditure.

Mr. HORSLEY supported the motion, and urged that they ought to go straight to the Privy Council with a statement of the facts of the case and ask for a decision as to who was the supreme authority in medical education, a decision which he was confident would be in favour of the Council.

Sir WILLIAM THOMSON pointed out that the Council existed, presumably, for the purpose of controlling and directing medical education, and if the Council possessed any authority it ought to be exercised. If on the other hand they had no such authority, they should cease issuing instructions which were received by the licensing bodies with contempt. He announced his intention of supporting any proposal to apply to the Privy Council.

Sir CHRISTOPHER NIXON observed that they appeared to be as far from a settlement as ever, and he apprehended a movement of disintegration.

After some further discussion, including some remarks from Dr. MACALISTER adverse to the proposal, the motion was carried by 16 against 10. The Committee was nominated accordingly, to meet in February next.

#### INSTRUCTION IN ANÆSTHETICS.

The Education Committee brought up a report in regard to a communication from the Society of Anæsthetists, urging the desirability of including in the curriculum of medical examinations the administration of anæsthetics. The Committee, however, did not see their way to making instruction in the administration of anæsthetics a compulsory subject. The report was adopted.

#### THE GOVERNMENT OF INDIA EDITION OF THE PHARMACOPEIA ADDENDUM.

On the recommendation of the Pharmacopœia Committee the issue of a "Government of India Edition" of the *Addendum* to the Pharmacopœia was authorised.

#### THE MULTIPLICITY OF PRELIMINARY EXAMINATIONS.

On the motion of Dr. WINDLE it was agreed to forward the memorial from the committee of the Headmasters' Conference, on the disadvantages arising from

the multiplicity of examinations qualifying for entrance to the various professions, to the Lord President of the Privy Council with the suggestion that the question was one suitable for the consideration of the consultative committee to the Board of Education.

## Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, Dec. 7th, 1901.

At the Dermatological Society, Hr. Held showed two cases of

#### ELEPHANTIASIS OF THE EXTERNAL GENITALS

after bilateral operation for bubo. The first case was combined with syphilis. In the second case (ulcus molle) the course was very protracted after extirpation of the bubonic glands. Even whilst the patient was in hospital some swelling of the scrotum was observed. In the first case the swelling did not begin until two years after the operation. In both cases there was extensive enlargement of the scrotum, and a partial elephantiasal enlargement of the penis that led to actual deformity and flexion of the organ. In the second case, erysipelatous feverish attacks had been frequent, with a temperature up to 104° F. In one case the appearance of a lymphorrhœa was remarkable, shown by the cropping up of small vesicles. These opened, either by themselves or by intent, gave vent to a continuous stream of clear watery fluid. Surgical measures had so far afforded no assistance.

Hr. LASSAN pointed out the importance of the cases brought forward in regard to the question of radical operation for bubo. He himself had observed a similar case in a young woman. Saenger, of Leipsic, had obtained good results as regarded the lymphorrhœa by cauterisation of the vesicles.

Hr. WECHSELMANN drew attention to the cases of elephantiasis of the leg that had followed extirpation of lymphatic glands.

Hr. HELD in reply, said that he had already applied caustics. The patient complained of feeling very uncomfortable after the stoppage of the discharge. He would report further as to the later course of the cases.

#### COCAINE IN OBSTETRIC PRACTICE.

Hr. WESTPHALEN has a paper on this subject in the *Cbl. f. Gyn.*, 37/1901. He first made some experiments with it in various forms of lingering labour, applying it to the floor of the pelvis. He found that it did not prevent reflex abdominal pressure, but that on the contrary it increased it to an extraordinary extent. It was clear that by partial anæsthetisation of the pelvic floor certain inhibitory reflexes were temporarily abolished, so that the expelling power of the abdominal muscles had free play. For the past two years he has been employing cocaine in this way in cases in which, with low-lying head, dilated or nearly dilated os, and ruptured membranes, abdominal pressure does not come on, or only imperfectly; further also, in cases of spasmodic contraction of the uterus and in those cases where severe pain remains during the pause between the pains. The pains became regular in from five to ten minutes after the introduction of a cocaine suppository, and remained so. No ill effects have been observed. Larger doses than 0.03 gramme have never been ordered, but a second suppository has been given in an hour and a half if necessary. It was never noticed that the pains became weaker, but the abnormal pains were relieved.

## PUERPERAL ECLAMPSIA.

The same journal (No. 40) contains a paper dealing with certain points in puerperal eclampsia, by Dr. W. Herzfeld. He remarks that in eclampsia in the first stage of labour in primiparæ, pressure on the ureters is found very frequently, which in the absence of material kidney or liver changes must be looked upon as important from an ætiological point of view. In eighty-one autopsies hæmorrhagic hepatitis was found thirty-two times; in four of these there was also compression of the ureters. In another twenty-eight cases there was parenchymatous degeneration of the liver and kidneys, also with four cases of compression of the ureters. In twenty-one cases no symptoms referable to the liver were observed. In 32.3 per cent. of the cases (eighteen times) there was bilateral compression of the ureters; in 46.6 per cent. (thirty-eight cases) chronic Bright's disease, with more or less grave changes in the heart, and in 31.1 per cent. (twenty-five times) parenchymatous degeneration of the kidneys, acute nephritis, &c. From a consideration of these facts, and from the typical occurrence of compression of the ureter in primiparæ in whom eclampsia occurred, the writer draws the conclusion that in the majority of cases the disposition to the outbreak is due to changes in the uropoietic tract. Further support to this view is given by the cases in which eclampsia occurs in the earlier stages of pregnancy. In these cases serious nephritic changes are always present, and often were so before the pregnancy began, a circumstance of great importance as regards prophylaxis. In spite of these views the author does not speak of a uræmic eclampsia, but believes that the eclampsia is an intoxication. If these views, on being tested, are found to be correct, early delivery will be indicated, and perhaps even Cæsarean section, as being the quickest mode of effecting it without further damage to the urinary organs.

## Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, Dec. 7th, 1901.

## ARSENICAL DERMATITIS.

At the "Gesellschaft der Aerzte" Lang showed the photograph of a patient suffering from dermatitis with acute exudation induced by the use of arsenic. He showed the photograph with the object of confirming Neumann's opinion, to which he referred at the meeting last month, when he showed a patient suffering from the same symptoms on the palms of the hands and soles of the feet, from which the dermis could be removed in layers. The other affections occurring on the same localities, such as lichen rubra and syphilis, are easily distinguished by their appearance and course, and although malignant carcinoma closely simulates the disease, it also is easily distinguished.

## TRAUMATIC CARDIAC HYPERTROPHY.

Benedikt showed a patient who had fallen from a scaffold nine months ago. After the accident he was well till about two months ago, when he was seized with extreme cyanosis and dyspnœa. This patient was in perfect health before the accident, and even retained that appearance up to the beginning of October last, when he became deeply cyanotic, with great dyspnœa. On examining the heart, it was found to have the apex

beat in the axillary line, while the second aortic sound and Röntgen rays clearly demonstrated hypertrophy of the organ. The diagnosis was further confirmed by a subsequent reduction of the cardiac area associated with arterio-sclerosis. This was described in the clinical notes as acute aortitis, with softening and curvature of the aorta and pulmonary arteries.

Braun thought this was not a case of simple hypertrophy, but one of dilatation, to which Benedikt replied that the nodular hardness of the cardiac muscle could be felt through the walls of the chest. Braun adhered to his diagnosis, and thought that from the cardiac impulse hypertrophy of the organ must be cautiously accepted, pointing out that the nodular thickening might also be produced by a dilated auricle or enlarged pulmonary valves.

## LEAD AND TENIA.

Pauli showed a worm he had obtained from a patient under treatment by male fern. The special feature was the colour of the parasite, as the young proglottides were white, while the older members were of a dark gray colour. The host was a painter and had repeatedly suffered from plumbism, for which he had been successfully treated. At the time he parted with the worm he was free from any symptoms of lead poisoning, which seemed to justify the presumption that the colour of the tænia was due to the lead taken into the system, which was supposed to have been eliminated by the bowels where it would come in contact with sulphur evolved from decomposition in the bowel and subsequently become deposited in the parasite. The older members being deeply coloured while the younger were free, supported the hypothesis. Another idea was that the sulphur of the proteids in the tænia split up and took on the colours present that were transmitted to their descendants. The splitting up of albuminoid bodies in alkaline fluids favoured this opinion.

To set these doubts at rest the worm was submitted to Prof. Mauthner for chemical analysis for lead, but no trace of that metal could be found.

This fact conveys a practical lesson, viz., that the discovery of a worm is not an assurance that the patient passed it. It is therefore necessary to note that these worms are not always white when dead.

## IS FAT EVOLVED FROM ALBUMEN ?

To determine the question under discussion by physiologists, Horbacyewski, of Prague, selected three young dogs for experiment. No. 1 was killed and the fat carefully separated and weighed. From this proportion of fat that of the other two dogs was calculated. No. 2 was fed on a purely albuminous diet, containing only a small quantity of fat and milk sugar. No. 3 was fed daily with 5 grammes of fat with the minimum amount of albumen. At the beginning of the experiment No. 2 weighed 1,430 grammes, which corresponded to the standard given by No. 1 of 141 grammes of fat. After deducting for loss by the bowel the daily intake might be shown thus:—

Albumen, 49.094 grammes	} = 196.11 calories.
Fat, 0.074 "	
Sugar, 0.072 "	

At the end of fifty days it weighed 1,380 grammes, or 50 less than at first; the fat of the body was 38.48 grammes, or 102 grammes less than it should be in the same proportion as No. 1. No. 3 had an original weight of 1,290 grammes, and a daily intake of

Albumen, 34.4 grammes	} = 189.7 calories.
Fat, 49.5 "	
Sugar, 0.6 "	

At the end of thirty days it weighed 1,440 grammes, or an increase of 150. From this he concludes that albumen produces no fat in the animal economy, and therefore both albumen and fat must be provided to support the organism.

### Lunacy Department.

#### THE LABORATORY SCHEME FOR THE IRISH ASYLUMS.

THE sympathetic allusion of the President of the Royal College of Physicians of Ireland, in his address at the Catholic University School of Medicine, Dublin, which was recently published in these pages (a), may recall to the minds of our readers an editorial (b), published earlier in the year. In this article we dwelt at some length on the unfortunate lack of facilities for the study of the pathology of insanity which prevails in Ireland as compared with most other civilised countries, and commended to our readers' consideration the very feasible project which is at present on foot for the supply of this deficiency. We are glad to be able to state that some further steps in advance have since been made towards the fulfilment of this scheme. At that time progress was effectually barred by the legal inability of asylum committees to contribute from asylum funds towards any such object. As Sir Christopher Nixon mentioned, this barrier has now been removed. By a special clause introduced into Lord Ashbourne's recent Act (1 Edw. VII., ch. 17, sec. 5) "the committees for any two or more district lunatic asylums" are empowered to combine for the establishment of such a laboratory as would be required, and to defray the expenses thereof from the asylum funds. This important step is certainly a matter for congratulation to all concerned, and it is encouraging to note that its success was secured not alone by the sympathy of the Chief Secretary and the Lord Chancellor of Ireland, but by the co-operation of individual members on both sides of the House. Indispensable, however, as this measure was, it is after all only a preliminary, and the real battle has still to be fought out in the Asylum committee-rooms and the County Council chambers. The campaign, indeed, has already been opened by the Laboratory Committee of the Irish division of the Medico-Psychological Association, who have written to all the medical superintendents of asylums in Ireland, inviting their co-operation, and urging them to use their influence to win over to the scheme their respective committees. To assist the superintendents in their efforts a circular has been drawn up for general distribution, explaining the need for, and the objects of, such a laboratory. We understand that a number of the superintendents have not yet answered, but many have expressed their approval and have placed the circulars in the hands of their committees. It is satisfactory to know one of the latter bodies has already given proof of the enlightened spirit which animates it by promising an annual contribution of no less than £60, a good example which, we trust, will be widely followed. It cannot be too strongly urged upon the superintendents

(a) THE MEDICAL PRESS AND CIRCULAR, November 27th, 1901, p. 567.

(b) THE MEDICAL PRESS AND CIRCULAR, April 10th, 1901, p. 395.

of Asylums that the success or failure of this promising scheme lies to a large extent in their hands. If the committees, as they should, look to the medical officers for guidance in matters purely professional, they cannot be blamed if they refuse to entertain a proposal which the superintendents evidently regard with indifference. Such indifference would not only be prejudicial to the best interests of the public at large, but would indirectly have a most injurious effect on the status of the alienist. If alienists are to occupy that position in the ranks of the profession to which they are entitled, it can only be by cultivating in their own department that scientific spirit which is more and more leavening the profession at large. Only thus can they do their best for their patients, and only thus can they rise above that merely administrative view of their duties with which so many have in the past been satisfied. As a means to this end, as well as in the interests of the prevention and cure of insanity, we earnestly recommend this scheme for their support, assured that whatever form it ultimately takes, whether that suggested by Sir Christopher Nixon or some other, it cannot fail to exert a far reaching beneficial influence both upon patients and physicians.

### The Operating Theatres.

#### GUY'S HOSPITAL.

UNUSUAL CASE OF APPENDICITIS.—Mr. AEBUTHNOT LANE operated on a woman, *æt.* 30, who for many years had suffered from recurrent attacks of what appeared to be obstruction of the colon in the situation of the hepatic flexure. This was associated with a considerable amount of disturbance of the pelvic organs, and with some evidence of recurrent trouble of the appendix. The whole length of the ascending colon was freely exposed, when the hepatic flexure was found to be tied down by abundant adhesions extending inwards from the abdominal wall external to it—a condition to which Mr. Lane said he first called attention in a lecture on movable kidney, published in the *Clinical Journal* of this year. These bands were freely divided, and the hepatic flexure was completely liberated from the position in which it had been retained by them. A similar plane of peritoneal adhesions was removed along the whole length of the cæcum on its outer aspect. The appendix was then found to be fixed deeply in the true pelvis, its extremity being attached to the outer limit of the Fallopian tube whose orifice it had occluded, the tube being considerably distended, so as to form a hydro-salpinx. The distended tube was removed from the ovary when the appendix was freed from its attachments and excised, the stump of the appendix being buried by a purse-string suture. Mr. Lane pointed out that the chief symptom from which the patient had suffered was not the primary trouble in the appendix, nor that set up in the Fallopian tube, but the obstruction in the situation of the hepatic flexure produced in consequence of very extreme constipation lasting over a period of many years. This condition had been described, he said, in the lecture he had before referred to, and was one of very considerable importance because of its frequency. Disappointment frequently

ensued, he remarked, when, after operations for the removal of the appendix, the patient continues to complain of recurrent attacks of the pain and tenderness in the cæcal region produced by distension of this portion of the gut, which is consequent upon an obstruction of the hepatic flexure; this obstruction is produced by the contraction of an acquired mesentery or a band of adhesions which may have resulted simply and wholly from chronic constipation, or as a part of a general tuberculous peritonitis, or of a peritonitis produced by inflammation in and about the appendix; therefore the surgeon should explore this region thoroughly when there is any suspicion of interference with the lumen of the flexure and not rest satisfied with excising an appendix, the inflamed condition of which may merely be produced by the constipation, which is the common factor in the development of both.

The patient, ten days after operation, is in a very satisfactory condition.

#### EXCISION OF PART OF THE STOMACH FOR CARCINOMA.—

The same surgeon operated on a man, æt. 43, suffering from cancer of the pyloric end of the stomach, which extended along the lesser curvature, and along both surfaces of the wall of the viscus for a considerable distance. He had previously performed a gastro-enterostomy upon the patient since the case first came under his observation, the condition of the patient being then such as to render any more serious operation inadvisable. The growth was freely exposed and separated from the surrounding parts; it was then excised, the openings of the duodenum and stomach being closed. A quantity of gauze was left in, which it was intended to remove in part from day to day. Mr. Lane said that, as he was unable to find any secondary growth and but very slight glandular infection, he hoped that he had increased considerably the length of the patient's life by the second operation.

A fortnight after operation the patient was going on in a very satisfactory manner.

**OPERATION FOR PHYSICAL DISABILITY RESULTING FROM THE UNSATISFACTORY UNION OF THE FRAGMENTS OF A RADIUS, WHICH HAD BEEN BROKEN AT THE JUNCTION OF THE UPPER AND MIDDLE THIRD.**—The same surgeon operated on a boy, æt. 16, whose radius had been fractured thirteen weeks before, and who had been treated by a very skilful surgeon in the usual manner. When the splints were removed, however, he found that the forearm remained in a semi-prone position, supination being impossible, while pronation was exceedingly limited. It was clear that although bony union had ensued the axes of the fragments no longer corresponded with one another. The arm was practically of very little use to the patient. The seat of fracture was exposed by a long incision, and the radius was divided in two oblique planes, by means of which the axes of the fragments were made to correspond accurately, and the bone restored to its normal form and functions. They were retained immovably in this position by means of silver wire. This condition of incorrect union of the radial fragments is, Mr. Lane said, in a more or less marked degree a comparatively common one, and has frequently called for operative interference, the results being uniformly satisfactory. The chief difficulty in operations of this class is to determine with accuracy the exact obliquity of the two planes in which

the bone has to be divided, and if the surgeon is successful in doing this, does not hesitate to make a long incision, and keeps his fingers out of the wound, he will find, Mr. Lane thinks, such operations most beneficial.

Three weeks after operation the range of pronation and supination was complete, and the functions of the arm were normal.

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## The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, DECEMBER 11, 1901.

### THE GENERAL MEDICAL COUNCIL AND THE ROYAL COLLEGES.

THE protracted discussion which took place at the meeting of the General Medical Council last week on the proposed revision of the regulations for the registration of medical students has not given any appreciable result, except to show that the Council is profoundly divided on the subject. In truth the Council has probably acted wisely in abstaining from what would have amounted to a revolution in its scheme of medical education, especially as it was abundantly evident that the example of the Royal Colleges of London in setting the authority of the Council at defiance is likely to be followed by the other licensing bodies and universities as, and when, an occasion presents itself. The proposal before the Council was to defer the completion of student's registration until he should have passed an examination in scientific subjects in addition to the earlier examination in subjects of general education. It was hoped thus to find a means of obviating the difficult situation created by the action of the Royal Colleges, but even the Education Committee was so hopelessly divided on the proposals laid before it that no formal report was found possible, and the Chairman of the Committee was fain to delegate to another member the task of moving the adoption of the proposal embodying this principle. It seems to be generally admitted that, technically, the Colleges were in their strict right in claiming to recognise the institutions at which

scientific instruction might be imparted, but the moral effect of the brutal method in which they formulated their claim has proved most disastrous; indeed, the Council has lost in great measure the power which it had gradually assumed of controlling the education of medical students *ab initio*. That the exercise of this authority, hitherto tacitly conceded, has been all to the advantage of medical education, no one, we imagine, would contest, but since that tacit understanding no longer holds good, and in view of the fact that most of the other licensing bodies and universities threaten to break loose, the Council may well consider whether the moment has not come to appeal to the Privy Council or to initiate legislation conferring the necessary powers on the Council. We fail to see that there is any obvious advantage in including purely scientific subjects in the medical curriculum. The University of London does not insist upon any set course of lectures from candidates for its degrees in science, yet no one could pass their examinations unless he had been through a thorough course of training. Why, then, should it not be left to the various licensing bodies either to hold an examination of their own in these subjects, or to exact other evidence of adequate training and knowledge? The curriculum, which need not exceed four years under such an arrangement, could then be exclusively devoted to strictly medical subjects. By rejecting the proposals brought before it the Council has left matters as they were, and the position is anything but edifying. Radical measures will have to be taken before the Council can hope to regain its former authority in medical education, and every delay further complicates the inherent difficulty of the situation.

#### PRACTICAL ASPECTS OF MEDICAL REFORM.

It has been long admitted by the thinking classes of the community that the regulation of medical practitioners is vital to the well being of the State. That position has been formally recognised by the laws that have been placed upon the Statute book with regard to the course of preliminary and professional education and to the granting of qualifications to practice. The safeguarding of legitimate medical work is of importance not less to the members of the medical profession than to the outside public in whose interests the profession have been brought into being. So far as the current of medical opinion can be gauged the attempts of the legislature have failed miserably in both directions. Qualified practitioners on the one hand are robbed of legitimate practice, while on the other the public are the easy prey of a host of quacks, charlatans, and, in not a few instances, of cruel and fraudulent swindlers of the Viavi and Mattei cancer cure and Harness electrical belt nature. It is nobody's business to suppress these deadly parasitic foes to the welfare of society. The General Medical Council make no such attempt on

behalf of the medical profession, and the Legislature and Government are equally inert with regard to the general public. The existing medical acts, imperfect though they be, are not administered with anything like the thoroughness that might be looked for from a governing council that regarded the protection of the interests of the profession as a sacred trust. Neither are those Acts brought into requisition by the police and the Public Prosecutor, as often might be done, in the case of many fraudulent and criminal offences of a quasi-medical nature. What, then, is to be done in order to bring under control at any rate the more rampant and dangerous of the myriad forms of medical quackery that now flourish at the expense of the community? The immediate means will probably be found in a temperate and well-considered reform of the medical acts, a consummation devoutly to be wished for by every member of the medical profession. Behind that reform, however, lies the education of both the people and of the parliamentary representatives as to the desirability of protection against irregular medical practice. To the ordinary common sense mind it would stand to reason that if it be necessary to protect the public against the qualification of imperfectly educated medical practitioners, it would be a thousand times more imperative to guard the citizen against the wiles of the unqualified and untrained pretender. Yet while the legislature and the General Medical Council surround the path to qualification with conditions that are ever increasing in number and in stringency; yet on the other hand they take no steps to check the flowing tide of charlatanism. The situation from this point of view represents the essence of topsy-turvydom, and would be highly humorous were it not that the official neglect in question entails a vast annual loss in life and in damaged health. A reformed General Medical Council might do an immense service both by educating the public and by bringing pressure to bear upon the legislature. Under present conditions, however, it seems hopeless to look for help from a body that is conservative to a degree, and is mainly representative of collegiate interests sundered by a wide gulf from those of the medical profession. An increase of Direct Representatives upon the Council could hardly fail to impress upon that body the importance of a wider interpretation of its duties and responsibilities. Another way in which a great step towards the reform of the Council might be effected, would be by the members of colleges and the graduates of universities insisting upon choosing their own representatives. As things stand the licensing bodies are governed by a small knot of irresponsible persons who choose one of their number to sit at the Council. In that way an overwhelming majority of the General Medical Council is formed of the representatives of interests that are for the most part alien from the main mass of the profession. Here, then, is a practical issue in which every medical practitioner, whatever his position, can join, namely,

an agitation to give the members of every qualifying body the right to choose their own Council representative. In this way it may be hoped to bring the General Medical Council to recognise that one of their main functions is to indicate to the legislature the direction in which reforms should be instituted, not only as regards the medical profession, but also the public, inasmuch as they have been created to protect and further the interests of both those classes.

#### A NEW GENERAL ANÆSTHETIC.

THERE are a number of minor operations in surgery that occupy from five to twenty minutes, a period of time too long for completion under the anæsthesia of nitrous oxide gas. To meet this difficulty the admixture of oxygen and nitrous oxide has been tried, but the compound has not met with general favour, and its use has never been very general. Cocainisation of the cord in the hands of some French surgeons has given good results, but in quite a number of cases the results have been disastrous. Schleich's infiltration method has gradually lost ground, if, indeed, it could ever be said to have been in favour in this country. For a time the freezing methods by evaporation of ether and chloride of ethyl were tried, but at best they were only suited for a very limited group of cases. It is, therefore, with pleasure that we note the good results that are being obtained by the use of pure chloride of ethyl as a general anæsthetic. At the recent Congress of Surgery, M. Malherbe, who has been using the anæsthetic since 1898, when he first used it in the clinic of Professor von Hacker, speaks highly of its properties as an anæsthetic and its comparative freedom from toxic or other undesirable after effects. We concede that the chorus of praise which ushers in new remedies should be largely discounted without there are good grounds for anticipating that the drug will prove a satisfactory and safe general anæsthetic for minor operations generally. We will do no more than draw attention to the fact that it belongs to the ethyl group, and that its percentage of chlorine is small. All the volatile ethyl compounds have anæsthetic properties and, as a rule, are not lethal; indeed, the oxide of the radical principally produces its injurious effects by producing inflammation of one or more of the tissues than by direct action as an anæsthetic. One of the great troubles of the use of the oxide is its irritating suffocative effect on the respiratory mucous membrane which the antecedent use of nitrous oxide or chloroform does not wholly overcome. The chloride of ethyl, if we are to judge from the clinical reports, has no irritant action on the respiratory tract, and it has the further advantage of acting very quickly, and is not followed by the headache, vomiting, bronchial irritation, and renal pains which so often follow etherisation. The patient quickly recovers from the anæsthetic effects of the vapour, and the return to consciousness is complete. M. Malherbe (*Le Progres Médical*) em-

ployed the anæsthetic 170 times without one unpleasant result, and in each case found the effects of the chemical were uniform. We cannot, however, judge from the experience of one surgeon in so small a number of cases, but we think a good case is made out for its tentative use.

### Notes on Current Topics.

#### Sanitary Measures in India.

A BLUE-BOOK just issued contains the report, prepared for presentation to Parliament, on sanitary measures in India during the year 1899-1900. In it are to be found chapters on the health of European and native troops, of prisoners in gaols, and of the general population. There are as well chapters on vaccination, on medical institutions, and on sanitary works. In appendices are abstracts of reports of the three principal sanitary commissioners in India, and memoranda by the Army Sanitary Commission in England reviewing the several sanitary reports for India. It is stated that the health of the European troops in India is much more satisfactory than it was in 1898-99. As usual, venereal diseases head the list of the causes of admissions to the hospitals and of the causes of invaliding. They were the cause of 27 per cent. of the total sickness during 1899, and of over 20 per cent. of the invaliding of the European army of India. In this connection we are pleased, however, to find that the admission-rate from venereal diseases per 1,000 of strength was 313·4, or 49·5 per 1,000 below that of 1898, and 208 per 1,000 less than the *maximum* rate (522·3) recorded in 1895. This the Army Sanitary Commission considers to be "a practical proof of the success of the sanitary measures recently enforced with the object of preventing these diseases from spreading amongst our young soldiers in India." These figures are decidedly encouraging, but it is greatly to be hoped that they may yet be still more materially decreased in future years. All four commands shared in the decrease, but it was most marked in Bombay and Bengal. An increase is recorded in the number of persons successfully vaccinated. Between seven and eight millions of the population were protected against small-pox in the year 1899-1900.

#### The Mortality among File-Makers.

THE ordinary observer would hardly suppose that file-making is one of the most deadly trades in Great Britain, yet, if we are to believe the statistics of Dr. Robertson, the Medical Officer of Health for Sheffield, it is so in reality. According to his statement—and he has devoted for some years past an unusually extensive portion of his report to the subject—the file-cutters pay a fearful tribute of death and disease every year. Among lead-workers 211 persons die every year from plumbism, and the same cause claims seventy-five file-cutters and seventeen potters. From other diseases attributable to lead poisoning the numbers per year are: file-cutters 1,514; potters 1,482, lead-

workers 1,421. The extraordinary mortality among file-cutters from plumbism and diseases derived therefrom is due to the method in which they carry out their trade. The file-maker does not use lead in the same way as either the lead-worker or the potter, but he places the file upon a leaden pad while he strikes the teeth. The sharp, incisive blows which he makes must disintegrate this piece of lead in some measure, and produce a fine impalpable lead dust which permeates the atmosphere. The places in which this work is carried out are nearly all old and out of repair, many of them being ruinous and dirty. The cubic space of air apportioned to each worker is totally inadequate, and the whole surroundings in which the trade is carried out are a crying disgrace to any country claiming to be civilised. How long will the legislature allow 1,000 cubic feet of air-space for the convicted criminal, and consider that 250 feet is ample for the artisan who works at file-cutting? Space will not allow us to quote the evidence that is brought forward by Dr. Robertson as to over-crowding in the file-workers' shops, but it can only be described as appalling. The same must be said of the sanitary arrangements of the shops, or, rather, the absence of such arrangements. The indictment brought against the Sheffield work-shop system by the health official of that city is a very heavy one. One cannot but feel that it is in this system of workshops, in which no man or woman can work at any occupation and keep healthy, that the dangers of trades lie, and nothing short of a drastic legislation will bring about any amelioration.

#### The Reputed Deterioration of the Race.

CERTAIN alarmists have drawn attention recently to the deterioration of the English race. It has been said that the war has shown, by the small percentage of men who are up to the required standard for service, that Englishmen are degenerating from a physical point of view. It is, however, very questionable whether this be so. It must be remembered that war imposes a special strain for which civilians are usually not prepared by training, and a physical endurance not required in ordinary life. Therefore, to assume upon such data that a race is deteriorating is altogether erroneous and fallacious. It has been proposed to measure and weigh school children twice a year in order to find whether the suspicion of deterioration is justified, but we fail to see how far such a process would prove preventive. Whether these suspicions be correct or no, the importance of prevention is paramount. More care must be taken in the education of our children, and their work must be better adapted to their relative capacities. That great and terrible curse of the country, the craving for stimulants induced by the arduous struggle for existence, must be met and overcome. The cure for deterioration of race lies in preventing excessive drinking, in stopping the over-taxing of the physical system, in remedying the transmission of an evil heredity in the perpetuation of the race, in securing the best possible kind of education for our children, and in arming them to

secure the best possible future for themselves and their offspring. It occurs to us that one outcome of the war is certain; the experience which has been gained by our soldiers after their long and severe exertions will result in our possessing the finest modern army in the world.

#### Sleep by Machinery.

ACCORDING to a colonial contemporary there are several novel sleep-producing contrivances upon the market, nearly all of which are designed to concentrate the user's attention upon one set of sensory impressions, so inducing the advent of nature's sweet restorer by a kind of self-hypnotism. A complicated arrangement called an "alouette" is one of them. It consists of a compact mahogany box, five inches high, four wide, and three and a half deep, from the top of which projects a nickel pivot penetrating the centres of two horizontal rectangular ebony panels, eight inches high by one inch wide. Clockwork in the box causes a series of ebony panels to revolve, each of which is studded on both sides by a horizontal row of bright, circular mirrors, of small size. The velocity maintained is one revolution a minute. Sleep is procured by darkening the room, save for one bright pencil of light arranged to fall upon the mirrors so that it is reflected into the eyes. Concentration upon the revolving panels of the gaze practically hypnotises the user until sleep relieves his fatigue. Another and similar arrangement is the "lighthouse," in which a small flash light revolves like that used to warn the watchful mariner who skirts our coast. But the most complicated of these contrivances is one known as the "vibrating coronet," the invention of a Paris physician. This consists of three bands of metal encircling the head; a branch strip extends to either eyelid, and, by means of a spring, gently vibrates against it. We should imagine that this machine would have an aggravating effect rather than a sleep-producing one, and that it would serve to further accentuate the famous line of Shakespeare that "uneasy lies the head that wears a crown."

#### A Remarkable Statement.

ONE of the most extraordinary of the many inaccurate statements made by the lay press, especially when dealing with medical matters, appeared in the *Evening News* for December 4th. In connection with the death of Sir William MacCormac, we are told that he is said to have paid £500 for the skeleton of the Irish giant, O'Brien, which now stands in the museum of the College of Surgeons! It is a matter of common knowledge that the skeleton was obtained by John Hunter in 1783, and £500 was borrowed to bribe certain persons to obtain it. O'Brien, having a horror of being dissected, left strict orders that his body should be watched day and night until a lead coffin was made, in which it was to be enclosed and sunk at sea. His precautions were, however, frustrated, and the body was obtained by Hunter. The Hunterian Museum was, in 1799, bought by the Government for £15,000, and formed

the foundation of the museum of the Royal College of Surgeons. That Sir William MacCormac should be confounded with John Hunter, who lived a century beforehand, is certainly remarkable, even allowing a wide margin for journalists' ignorance of medical history.

#### Instruction in Anæsthetics.

IN view of the by no means insignificant mortality associated with the administration of anæsthetics in this country we must confess to a feeling of surprise that the General Medical Council has not seen its way to give effect to the memorial of the Society of Anæsthetists urging that instruction in the administration of anæsthetics should be made a compulsory subject of medical education. The curriculum, it is true, is well filled, and would with difficulty admit of additions to the schedule of requirements, but the administration of anæsthetics is a subject of such importance that the Education Committee might well have been expected to insist upon it, even if some minor branch of study had to be jettisoned to make room for it. It cannot be too widely known that the great majority of newly-qualified men get their first practical experience of the administration of anæsthetics when they start in practice. In large cities the services of a skilled anæsthetist are usually available, but this is not, and cannot be, the case in country practices where the practitioner, however inexperienced he may be, is fain to discharge the functions of the anæsthetist from time to time. It is highly probable that a large proportion of deaths under anaesthesia are due to lack of skill and experience on the part of the administrator, and the present unsatisfactory condition of things is likely to continue until students are systematically and compulsorily instructed in this important detail of everyday practice.

#### The Cruelty of Foie Gras.

THE sentimentalists who devote so much energy towards the suppression of experimental scientific research conducted upon the lower animals will find an abundant harvest of absolute wanton cruelty on all hands if they care to look for it. How many anti-vivisectionists, we wonder, eat foie gras? Do they know that it is made from the diseased livers of geese which are deliberately brought to death's door by treatment that is diabolically cruel? The unfortunate birds are cooped up indoors in boxes so arranged that the head alone can be moved. They are then crammed with a rich diet, which is forced down their gullet. Under these circumstances the liver quickly becomes affected, and in about three months has attained an enormous size from fatty degeneration. The larger the liver the more successful the process. The most valuable livers are those of a green tint; that is to say, fatty livers impregnated with bile pigments. The centre of this trade is Strasburg, which sends out annually about £150,000 worth of this delicacy. A recent petition to the civic authorities of London to exclude foie gras from the banquet recently given

to the Prince of Wales has excited the liveliest alarm among the merchants of Strasburg, inasmuch as, after Paris, England is their next best customer. Three months of forced feeding is required to bring the unfortunate birds to the proper pitch of organic degeneration, so that their livers may tickle the palate of fat gourmands. Of a truth, any anti-vivisectionist who eats foie gras is committing an act of farcical incongruity. On the one hand he is eating a toothsome morsel procured by a course of prolonged torture practised upon a harmless domestic fowl, while on the other he is railing at scientific men whose aim in experimentation is the highest conceivable—namely, the alleviation of suffering among mankind. Meanwhile, Strasburg flourishes and science is tied hand and foot in the United Kingdom.

#### Re-Election of Sir William Turner.

IT appears that we were under a misapprehension in regard to the purport of Sir William Turner's announcement in his Inaugural Address that he was about to tender his resignation. He has apparently no desire to be relieved of the burden of the presidency, as is evidenced by his acquiescence in his re-election, which was unanimously carried amidst applause. It must be a source of satisfaction to most members of the General Medical Council that the services of so experienced a President are to be retained for a further period of five years, and we congratulate the Council on their choice.

#### Children and the New Beer Regulations.

IN a few weeks' time the new Act, known as the Intoxicating Liquors (Sale to Children) Act, will come into operation. Neither of Mr. Balfour's Governments have done much to the furtherance of temperance legislation. At the same time, it was hoped by the friends of the movement that the small measure above-mentioned would remove one of the standing abuses of the publican's trade. From all we can gather, however, that desirable consummation is still afar off. It appears that the Act has been so loosely drawn that it will be the easiest thing in the world for the drink vendor to go on supplying children with any amount of liquor. The whole scheme of evasion has been planned out and has become public property, as set forth in notices and handbills distributed to the publicans. The Act makes it illegal to sell intoxicants to any child under fourteen, except in "corked and sealed" vessels. Parents are informed that they may send bottles or jars, which will be corked and sealed by the publican. The "sealing" can be technically carried out in the twinkling of an eyelid by merely affixing a gummed label. It has been stated that many publicans intended providing special vessels that may be bought, borrowed, or hired by customers. No quantity less than a "reputed" pint can be sold to a child, and the publicans will doubtless hasten to establish the capacity of that measure. Almost the only practical outcome of the new Act will be to prevent children drinking out of the can on their



way home. It seems absurd that Parliament cannot provide experts who can draft business-like and workable measures.

#### Antiseptic Doormats.

OF all the crazes that the inventors' brain has launched on the stream of time few can compare in grotesqueness with the antiseptic doormat. Latter-day science has shown that the reign of bacteria is well-nigh universal. Practically the only places devoid of these tiny organisms are high mountains, frozen climes, and mid-ocean. As everyone knows, many of the necessary processes of nature, as decay and fermentation, are carried on by the agency of bacteria. On the other hand, many maladies that attack mankind are caused by the invasion of microbes. In towns the dust is specifically contaminated by a vast amount of organic material, of which a good deal is doubtless brought into houses by the boots of inmates and visitors. To render those boots aseptic would require a prolonged exposure to hot air, and would certainly be beyond the powers of any doormat. Besides, even supposing the doormat to act as an efficient safeguard in preventing the entrance of boot-borne bacteria of evil nature, there is still the unceasing invasion of the house by air-borne microbes. From whatever standpoint the matter is viewed it is impossible to avoid the conclusion that the inventor of the "antiseptic doormat" is a crank whose misplaced ingenuity were worthy of a better cause. At the same time any adequate provision of doormats and scrapers is essential to every sanitary house. The systematic cleansing of the doormat is a point that does not always command the attention it deserves, even in otherwise well-regulated households.

#### The Health of Aberystwyth.

FOR some time past there have been rumours as to the unsatisfactory state of Aberystwyth from a health point of view. At a recent Council meeting one of the members, Mr. C. M. Williams, stated generally that the townfolk had every reason to be pleased with the existing state of affairs. That statement has been vigorously attacked by a correspondent of the *Cambrian News*, who says there have been eight deaths from diphtheria during the past twelve months or so. Enteric fever has also existed in various parts of the town, and one of the largest ladies' schools is closed on account of an outbreak of scarlet fever. A communication of this kind is of vital consequence to the welfare of a health resort, and demands a full and impartial official reply. It is no use trusting to general and possibly *ex parte* statements by Councillors. What is wanted is a public declaration of what infectious disease has existed in Aberystwyth during the past few years; what provision is made for dealing with the same; and whether the record compares favourably or otherwise with other watering-places in North Wales. It is only by vigorous and candid measures that the confidence of visitors will be retained in that most beautiful and pleasant health resort. The policy of

many of the seaside towns of the United Kingdom in seeking to hide their sanitary defects is simply suicidal, as sooner or later the truth is certain to leak out.

#### Insanity in the Country.

A COUNTRY clergyman has recently called attention to the serious question of insanity in country parishes, which appears to be on the increase. That mental diseases are on the increase is proved by statistics, but that some country parishes are perfect hotbeds for its propagation is quite possible. In the past the rural population have been stay-at-homes, and the long-continued inter-marriages have caused a lamentable decline in intellect. The clergyman referred to has been for five years in charge of a parish containing under 300 inhabitants, and during that time one in every eight that have been buried have been insane. At the present time two are in the asylum and two in the workhouse as imbeciles. In the parish itself there are four of weak intellect, but harmless. Among the school-children there are some half-dozen with intellects much below par, and whose ability to earn a living is doubtful. This percentage of mental deficiency in one small parish of 300 is undoubtedly high, and points to the grave want of new blood in our rural population. At the rate of progression, or, rather, of retrogression, in the parish referred to there should be hardly a sane inhabitant in a few more generations. It is by no means uncommon to find, in small country parishes, some four or five families making up at least half the population, and everybody related to everybody else. It is a matter which calls for serious attention, or soon our rural peoples will have decayed intellectually beyond remedy.

#### Friendly Microbes.

A GOOD deal is being done to popularise that portion of science which has to do with the health of the community, and lectures given with this purpose are distinctly laudable. Such lectures should be simple in their language, and with a slight inclination towards the humorous. This was the method chosen by Professor Bottomley in a discourse recently delivered by him at Nottingham on the subject of "Microbes, Friendly and Otherwise." He described the different kinds of bacteria as like billiard balls, pencils, and corkscrews, and pointed out the different methods of their culture, taking the mould found on jams as a familiar instance. Many microbes serve a useful purpose and only a few are dangerous. People scarcely realise how much we owe to the services of the former bodies in the way they complete the cycle of life by separating the organic tissues and preparing the way for life again. To them we owe the flavour of our butter, our cheeses, the aroma of tobacco, and many other of the luxuries of daily life. It is, however, the ways of the bacteria of disease with which the laity should be acquainted, and with the methods by which they can best be met and vanquished. In this regard it is less with antitoxins and similar subjects

that their teachers should deal, but it should be pointed out that darkness and want of ventilation mean dirt, disease, wretchedness, and death, whilst light and air spell health, cleanliness, truth, and righteousness.

#### Cures for Baldness.

OF so-called remedies for baldness there is no end. many of them harmless and ineffectual, but some are injurious. The public appear to have an idea that there is only one cause for baldness, and fly to the hairdresser or quack who advertises in society papers, instead of to an experienced dermatologist. The barber recommends his special lotion, which is always infallible, although he himself may be bald, and the customer is satisfied, that is to say, until sufficient time has elapsed to prove its futility. The most remarkable theory of baldness, strangely enough, is put forward by an American physician. His idea is that air contains organic matter which, if retained in the lungs and absorbed damages the growth of the hair. To this organic matter he gives the name "trichotoxicon." He claims to have made experiments with this on animals which demonstrate its toxicity. He explains the more frequent occurrence of baldness in men as compared with women by the fact that men, being chiefly abdominal breathers, do not empty the apical air cells. Women, whose respiration is chiefly costal, are said to develop little "trichotoxicon," and hence have luxuriant hair. Consumptive persons, in whose consolidated air cells the air cannot stagnate, are also said to be very free from baldness. That a member of the medical profession should bring forward such an idea is remarkable, if indeed he be a medical man. The various causes of baldness are now well known, and apart from ringworm and alopecia areata, comprise seborrhœa capitis, acute specific fevers, syphilis, heredity and senility. To class all these causes together is not only unscientific but absurd. We cannot congratulate our American friend on his "discovery."

#### The Lay Press and Cancer Cures.

OUR daily papers have, apparently, not yet exhausted the subject of cancer cures. The latest "information" comes from the New York correspondent of a well-known morning paper, who tells us that a certain specialist in cancerous diseases, whose name we do not wish to mention, succeeded in curing a severe case of cancer by the Röntgen rays. We are also informed that the surgeon in question has "written an epoch-making chapter in medical history." It is really time that writers in the lay Press should either take some trouble to look up the subject they are writing about, or else refer to a medical man qualified to advise them on the subject in question. It is well known that the Röntgen rays have been used both for rodent ulcer and epithelioma for several years. Professors Finsen and Unna have repeatedly tried it, often with success, and they have been followed by many others,

so that our New York friend is by no means the first to make the "epoch-making chapter." Again, the case is described in the daily paper as a cancer which spread over the face, eating away the lower lip and chin. The disease was of eight years duration, and the patient thirty-five years of age. Might it not have been rodent ulcer or lupus? The duration of the disease is more in favour of either of these than of true carcinoma. The patient's age, however, is against rodent ulcer. The publication of such cases from second hand information, supplied by persons ignorant of the subject, is neither to the interest of the profession or the public.

#### Useless Exhibitions.

THERE has recently been an exhibition in London which can serve no useful purpose except to make money for the person who runs it. The public, however, is always drawn by fasting men and the like, and it is unlikely that the public taste will change for many years to come. The exhibition to which we allude is that of a South American, 34 years old, who, wrapped up in some 400 yards of flannel cut into strips, was placed in a "crystal urn" or stoutly-made triangular glass case. This urn was sealed up so as to be watertight and lowered into a metal tank filled with water. In this situation the man remained, without food or water, for a week. Incandescent lights were kept burning in the urn so as to illuminate the man and the whole tank, so that the curious gaze of sensation-mongers could be gratified. Air was conveyed into the urn and kept in motion by means of a tube and electric fan. Visitors who wished to do so, could talk with the man during his voluntary incarceration. The individual who chooses this curious and somewhat uncomfortable method of gaining a livelihood claims that by "throwing himself into a cataleptic trance for the first twenty-four hours and by auto-suggestion that food and drink are wholly unnecessary and unknown, he can live under water the allotted time without nourishment of any kind." He is stated to have performed his feat in the chief cities of Europe and America. We have never been able to see what good can accrue from these absurd exhibitions of so-called endurance. They do but pander to the morbid appetite for sensation which afflicts a very large section of the population, an appetite which is shown in many ways and is apparently universal among all peoples.

#### The Sale of Poisons by Pharmaceutically Unqualified Assistants.

THE Council is about to issue a notice, the terms whereof have been approved, calling the attention of registered practitioners who keep medical halls or open surgeries to the fact that for them to cover the sale of scheduled poisons by assistants not qualified under the Pharmacy Act to dispense the same, will expose them to be judged guilty of infamous conduct in a professional respect. Public and professional opinion will endorse the attitude o-

the Council in declaring such conduct to be professionally reprehensible, and no agitation will avail to modify that attitude. It remains to be seen whether it will pay to keep open surgeries with assistants duly qualified to deal with poisons or whether the difficulty will be got over by refusing to sell scheduled poisons. The latter course would be a permanent source of danger to the medical proprietor because any misconduct on the part of his unqualified assistant in regard to the sale of scheduled poisons would expose him to a summons to appear before the Council.

### The New "Journal of Obstetrics and Gynæcology."

WE understand that everything has now been settled with regard to the publication of the new journal, the first number of which will be issued early in January. No modern journal connected with medicine has ever been launched under more influential auspices, whilst the editorial and publishing departments are in capable hands. The leading idea is that the new journal shall be thoroughly representative of all that is best in the domain of obstetrics and gynæcology, in its widest sense, of Great Britain and her Empire beyond the seas. For a full list of those connected with the venture we would refer our readers to the announcement in our advertisement columns; they will there find every chief city of Great Britain editorially represented, whilst India, Canada, Australia, New Zealand, &c., send names which are favourably known in this connection.

### The Concentration Camp Mortality.

It is interesting, in view of the vigour of French criticism anent the regrettable mortality among the Boer children in the concentration camps, to note that official statistics show the mortality among infants put out to nurse—and these constitute a very large proportion of infants born—in Paris, *La Ville Lumière*, is 80 per cent.! This is in spite of complicated regulations, of ample facilities for first-class medical care, and the existence of numerous societies for the promotion of the welfare of infants and for preventing the depopulation of France! Compared with this the mortality among the children in the camps is almost a negligible quantity. "Oh wad some power the giftie gie us!"

### Small-pox in London.

THERE has been a steady increase in the number of admissions of cases of small-pox during the past week, the number actually under treatment being, on Monday night, 499.

THE death is announced, by telegram, of Surgeon-General Robert Harvey, O.B., D.S.O., Director-General of the Indian Medical Service, shortly after his return to India.

DR. JOHN WARREN EDGE, who is believed to have been the oldest member of the medical profession in England, has just died at Monkseaton,

Northumberland. He was 98 years of age, and he practised in Kirkby Stephen. He took his degree in 1828, and continued in practice until a few years ago. Three brothers, also doctors by profession, attained the ages of 94, 93, and 80 respectively.

GOVERNORS of the National Hospital for the Paralysed and Epileptic, Queen Square, are requested to take note of the fact that an important meeting is fixed for to-morrow (Thursday), when the problem of carrying out the recommendations of the Committee of Enquiry will come up for discussion. So far, of course, nothing has been done to carry these recommendations into effect, and it is extremely important that every governor who can possibly attend should do so, otherwise the reformation of existing abuses may suffer.

### PERSONAL.

DR. WALTER ESSEX WYNTER has been elected physician to the Middlesex Hospital.

SIR THOMAS BARLOW, F.R.C.P., has been elected a member of the Royal Institution.

H.R.H. THE PRINCE OF WALES has been installed as President of the foundation of St. Bartholomew's Hospital.

DR. GEORGE K. GIVEN, medical officer for Gortin, County Tyrone, has been appointed a magistrate for the County Tyrone.

DR. ROBERT THORNTON MEADOWS, the Mayor of Saltash, has been sworn in as a Justice of the Peace for the county of Cornwall.

MR. THOMAS BRYANT, F.R.C.S., will open the new out-patient department of the Bolingbroke Hospital to-day (Wednesday) at 3 p.m.

DR. J. E. O'CONNOR has been appointed Medical Officer of Health for the combined districts of Leicestershire, Rutland, and Warwick.

SURGEON-GENERAL W. TAYLOR, C.B., who has been appointed to the post of Director-General of the Army Medical Service, has just returned to England.

DR. STENSON HOOKER, of Hastings, has been presented with sundry articles of plate, subscribed for by friends and patients, on his leaving to take up his residence in London.

DR. PURDIE, Professor of Chemistry in the University of St. Andrews, has offered to place at the disposal of that body a sum of £5,000 for the purpose of building and furnishing a small chemical research laboratory.

ALTHOUGH the result of the election of a direct representative for Scotland to the General Medical Council has not yet been officially announced, we venture to congratulate Dr Bruce, the sitting member, on his re-election by a considerable majority over his two competitors.

PROFESSOR EDGAR CROOKSHANK has resigned the active duties of the Chair of Comparative Pathology

and Bacteriology at King's College, a post which he has occupied for upwards of fifteen years. In recognition of his services as founder and lecturer in this department he has been made Emeritus Professor.

PROFESSOR G. D. LIVING, of Cambridge University, was presented with a testimonial last week in recognition of his long and valuable services to chemical science. The testimonial took the form of a subscription portrait of himself, which is to be hung in the hall of St. John's, and a bronze bust, which will grace the chemical laboratory.

DR J. J. HOPKINS, Castlebar, has been presented with a beautifully illuminated address and valuable testimonial by a deputation from Leenane, where he had been medical officer for eight years prior to his present appointment in his native town of Castlebar. The presentation consisted of a valuable horse and trap and pneumatic tyres, massive lamps, and brass-mounted harness, as well as some valuable personal gifts, such as a large American roll-top desk, &c.

THE PRINCE OF WALES'S HOUSEHOLD.

H.R.H. THE PRINCE OF WALES has been pleased to make the following medical appointments to his Royal Highness's Household:—

Physicians in Ordinary.—Sir William H. Broadbent, Bart., K.C.V.O., M.D., Sir James Reid, Bart., G.C.V.O., K.C.B., M.D., and Sir Francis H. Laking, K.C.V.O., M.D.

Surgeons in Ordinary.—Sir Frederick Treves, K.C.V.O., C.B., F.R.C.S., and Herbert W. Allingham, Esq., F.R.C.S.

Honorary Physicians.—Robert W. Burnet, Esq., M.D., and Samuel J. Gee, Esq., M.D.

Surgeon Apothecary to his Royal Highness's Household in Ordinary.—Sir Francis H. Laking, K.C.V.O., M.D.

Surgeon Apothecary to his Royal Highness the Prince of Wales and to the Household at Sandringham.—Alan E. Manby, Esq., M.V.O., M.D. Chemist and Druggist.—Mr. Peter Wyatt Squire.

Scotland,

[FROM OUR OWN CORRESPONDENTS.]

ELECTION OF A DIRECT REPRESENTATIVE.

Although the result of the election which has just taken place cannot be officially announced until December 10th, it is generally understood that the counting of the votes has placed Dr. Bruce, of Dingwall, the late representative, at the top of the poll, so that the representation of the constituency remains as before. Pending a decision on some doubtful votes, the exact figures are not available, but it is understood that Dr. Robertson, of Glasgow, has some 600 votes; Dr. Walker, of Edinburgh, some 800; while Dr. Bruce has a substantial majority over both candidates. Doubt as to the validity of some votes has arisen through the voters appending unregistered qualifications to their signatures, and omitting those under which they were registered.

GLASGOW WESTERN INFIRMARY.—PROPOSED EXTENSION.

At the annual general meeting of this institution it was announced that the number of in-patients had increased by 479, and the out-patients by 1077 over the previous year. Though the ordinary income shows a satisfactory increase of £1,000, there was a deficit of £8,000 on the year, which has been made good out of the extraordinary income, consisting of legacies and large donations, thereby diminishing the capital funds by just so much. A new wing, estimated to cost £25,000, is in contemplation, and meanwhile the directors are proceeding with a new out-patient department which will cost £40,000, of which £20,000 has already been promised.

EDINBURGH SICK CHILDREN'S HOSPITAL.

Although the present hospital buildings have been in existence only a few years the original out-patient department is proving quite inadequate to the work carried on, and the directors have accordingly sanctioned plans for a new one, which will cost some £20,000. The ground floor will contain a large hall for medical cases, dressing room, consulting room, dispensary, and store, while the first storey is given up to the surgical, electrical, and ophthalmic departments.

NEW FEVER HOSPITAL AT BATHGATE.

A new fever hospital was opened at Bathgate on November 30th. It consists of two pavilions of twelve beds each, and two observation wards of two beds each, attached to the administrative block. The building has cost about £316 per bed. Dr. Anderson, Armadale, has been appointed medical officer in charge, and Dr. Kirk, Bathgate, of curling fame, the honorary consulting physician.

Special Articles.

MEMORIAL TO THE LATE DR. ARCHIBALD HAMILTON JACOB.

THE Committee of the Jacob Memorial desire to intimate to the subscribers of the Fund that they have applied the money collected in part payment of the purchase of the house, 47, Morehampton Road, for Mrs. Jacob and her daughters. They also take this opportunity to express in Mrs. Jacob's own words, "Her heartfelt thanks and gratitude to the many generous subscribers to the Fund, and to state that it has been some consolation to her for his irreparable loss to know that her late dear husband's professional friends and admirers hold in remembrance his life-long work in the interests of the profession, in token of which they have now come forward and assisted her so materially in her great trouble and bereavement."

The Committee herewith submit their account and distribution of the Fund.

HON. TREASURERS' ACCOUNT OF "JACOB MEMORIAL FUND."

	2 s. d.
Total Subscriptions received .. ...	361 19 0
	£381 19 0
<i>Disbursements.</i>	
Postage, Addressing Circulars, &c. ...	12 2 9
Brindley and Son, Printers ... ..	7 16 8
Handed to Mrs. Jacob, in part payment of House, 47, Morehampton Road...	362 0 0
	£381 19 0

- CHARLES A. CAMERON, C.B., 51, Pembroke Road, Dublin.
  - L. H. ORMSBY, Vice-President, E.C.S.I., 92, Merrion Square, Dublin.
  - GEORGE F. BLAKE, J.P., Registrar, Royal College of Surgeons.
- } Hon. Treasurers.  
} Hon. Secretary.
- December 6th, 1901.

Royal College of Surgeons, Ireland.—Fellowship Examination.

THE following candidates having passed the necessary examination, have been admitted Fellows of the College:—Mr. M. Ballesty, Mr. E. T. Coady, Mr. F. P. Colgan, Mr. H. C. Fox, Mr. P. G. Lodge, Mr. G. E. P. Mellon, Mr. E. F. Stapleton, Mr. F. S. Walker, Mr. R. J. White, and Mr. G. O'Keeffe Wilson. The following candidates passed the primary part of the Fellowship examination:—Miss L. A. Baker, Mr. M. Deeny, Mr. M. Fitzgerald, Mr. A. E. F. Hastings, Mr. M. E. Kapadia, Mr. E. B. Kenny, Mr. J. N. Meenan, Mr. W. L. Murphy, Mr. H. E. C. Rutherford, Mr. J. W. Rutherford, and Mr. F. C. Sampson.

## Obituary.

SIR WILLIAM McCORMAC, K.C.B., K.C.V.O.,  
F.R.C.S. E. AND I.

THE death of Sir William McCormac, which took place on Wednesday last, at Bath, deprives the medical profession of one of its best known and most eminent representatives. The announcement, coming as it did without any previous intimation of failing health, necessarily excited general surprise as well as regret. It seems, however, that for two or three months past there had been disquieting symptoms, for the relief of which he was advised to undergo a course of treatment at Bath. He took his first bath on the day preceding his death, and appeared markedly benefited thereby; but just before the time had arrived for the bath on Wednesday, an attack of syncope brought life to an end.

Sir William, who was born at Belfast in 1826, was the son of Dr. Henry McCormac, who was himself a distinguished and cultured physician, and made a reputation as an expert in tropical diseases. He was, moreover, a strenuous advocate of the value of fresh air in the treatment of phthisis. Sir William was educated at the Belfast Institute, until the time came for him to go to Dublin to study medicine, which he subsequently continued at the then dominant school of Paris. He took his M.D. at the Queen's University of Ireland, and in 1864 was admitted a Fellow of the Royal College of Surgeons in Ireland, and was shortly afterwards elected Surgeon to the Royal Belfast Hospital, a post which he held for six years, during which period he made a special study of injuries of joints. The services which he rendered to this institution in various ways were recognised in 1879 by having conferred upon him the honorary degree of M.S., followed, in 1882, by that of D.Sc., in addition to the gold medal.

The "tide in the affairs of men," so far as Sir William's career was concerned, came with the outbreak of war between France and Prussia in 1870. The British Red Cross Society organised a magnificent ambulance expedition, officered by a number of British and American surgeons, in which Sir William (then Mr.)

McCormac played a very prominent rôle as Chief Surgeon of the Anglo-American Field Hospital. They were ordered to Mézières, and thence to Sedan, which they reached on August 30th, just in time for the fighting. This foreign ambulance was so placed, and so well equipped in the matter of surgical appliances and comforts, as to be able to render services such as no other ambulance in either army was in a position to perform during this war. For a hospital they were assigned an infantry barrack on the rampart of Sedan, overlooking the Meuse, in which 384 beds were set up.

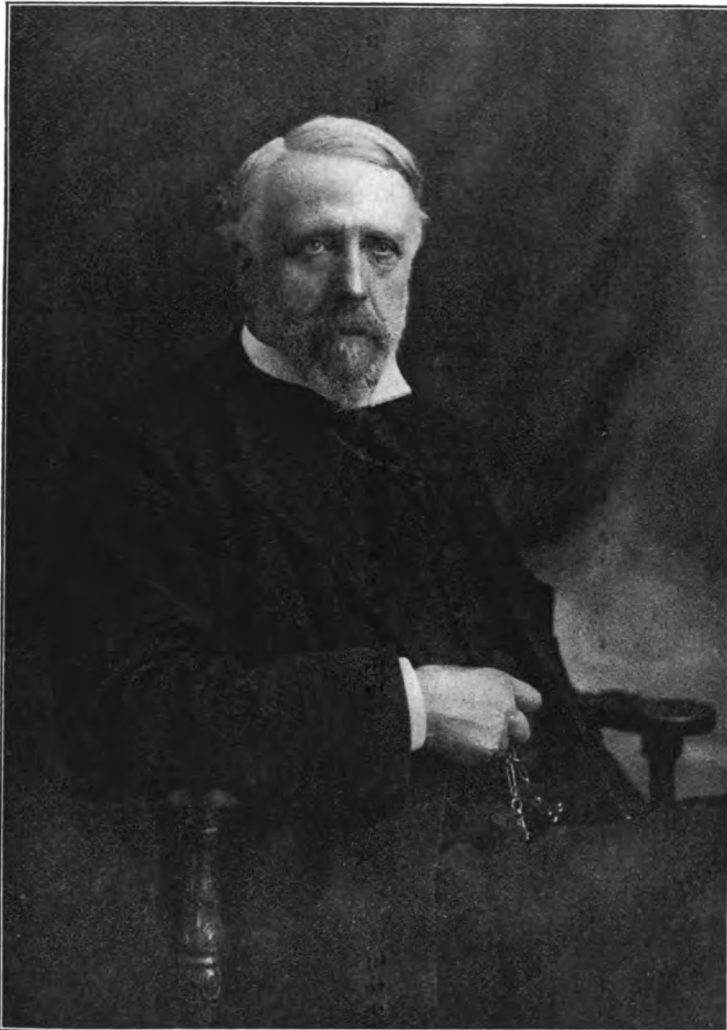
On August 31st McCormac, with several colleagues, went on to Balan, where no fewer than 260 wounded were attended to the same evening. On the next morning, September 1st, he was back in Sedan. The

French wounded were about 12,000, and of these 274 were received in the course of that day into the beds of the Anglo-American Ambulance, while many more were treated there and sent away. Each day considerably more than a hundred major operations were performed, and McCormac's share of these was a large one. A day of his work at the Caserne d'Asfeld is well described in his own words: "I did not succeed in keeping a record of all the work that was done that day. Indeed, I only wonder I kept any record at all. I find, however, that I performed several amputations of the leg, the thigh, the forearm, and the arm, that I excised the shoulder and the elbow-joints, and also performed partial resections of the upper and lower maxillæ and of

nearly the whole ulna. The number of bullets and pieces of shell that were extracted from various parts of the body are too numerous to reckon."

His energy, decision of character and robust constitution enabled him to withstand unheard-of vicissitudes and fatigue, including a smart febrile attack, the result of inoculation with infective discharge. In spite of his multifarious duties he kept a diary of his experiences in the field, the publication of which, in weekly instalments, brought his name prominently before the profession and the public, not only of his own country, but all over the civilised world.

On his return to England he became a Fellow of the



Royal College of Surgeons of England and was elected Assistant Surgeon to St. Thomas's Hospital, an institution with which he maintained his connection up to the date of his death. He settled down in Harley Street, as befitted his position, and in 1873 he was promoted to the full surgeoncy, and was appointed joint lecturer in surgery at the Medical School. In 1876 he paid a brief visit to the seat of war between Turkey and Servia.

In 1881 he had another great opportunity, as Secretary-General of the International Medical Congress, which was to meet that year in London. His faculty for organisation once again came into play, with the result that the Congress is memorable for its success, and he was rewarded with a Knighthood.

In 1883 Sir W. McCormac was elected to the Council of the College of Surgeons, and therewith began a closer connection with that body, which helped greatly to enhance his administrative reputation. In 1887 he joined the Court of Examiners, of which he became Chairman; in 1893 he began the Bradshaw Lecture, on "Sir Astley Cooper and his Surgical Work," and in 1896 he became President of the College, to be re-elected year after year. In 1897 he received a baronetcy among the Jubilee honours of that year, and was made Surgeon-in-Ordinary to the Prince of Wales, whom he treated successfully, soon after, for a fracture of the knee-cap, being rewarded with a K.C.V.O. Apart from his famous war diary and occasional addresses, Sir William did not publish much of importance, his best-known works being the article on "Gun-shot Wounds," in Heath's "Dictionary of Surgery," and that on "Hernia" in Treves's "System."

On the outbreak of hostilities in South Africa in the autumn of 1899, Sir William accepted the offer of the War Office to go out as Consulting Surgeon. He proceeded to South Africa in the company of Mr. G. H. Makins, who was also appointed Consulting Surgeon, Mr. (now Sir Frederick) Treves, following some weeks later, and he soon found himself among the wounded of Sir Redvers Buller's army after the unsuccessful attempt, in December, to cross the Tugela River and raise the siege of Ladysmith. He returned from Natal to Cape Colony, and proceeded to the Orange River to take charge of the arrangements for the wounded from

Lord Methuen's force advancing to the relief of Kimberley. A sharp attack of dysentery disabled him temporarily during his stay in South Africa, but he appeared to have made a good recovery.

Sir William McCormac remained up to the time of his death Consulting Surgeon to the Royal Belfast Hospital, St. Thomas's Hospital, the French and Italian Hospitals, and Queen Charlotte's Lying-in Hospital. His services, besides receiving recognition at the hands of his Sovereign, were rewarded by a very large number of foreign honours, among them the Legion of Honour, the Order of the Dannebrog, the Order of the Crown of Prussia, the Order of the Crown of Italy, the North Star of Sweden, the Order of Saint Jago of Portugal, the Order of Merit of Spain, and the Order of the Takovo of Servia. He was likewise honoured by the

Order of Ritterkreuz of Bavaria and the Medjidieh. His professional honours were also very numerous. He was member of a very large number of learned societies both at home and abroad, and at the great meeting of the British Medical Association in London in 1895 was President of the Section of Surgery, in which capacity he delivered an address which was greatly and justly admired, taking for his theme the advance of war surgery with special reference to the effects of modern projectiles.

Sir William McCormac married in 1861 Katherine, daughter of Mr. John Charters, of Belfast, who survives him. He leaves no children.

The funeral took place on Monday last, at the Kensal Green Cemetery, amidst a large and imposing concourse of colleagues and friends.

The British Medical Temperance Association held another meeting for medical students on Thursday, 5th December, in the Governor's Hall of St. Thomas's Hospital (by kind permission of the Treasurer). Dr. H. G. Turney, Dean of the Medical School, presided. In opening the conference, he said that he thought the medical profession rather lagged behind public opinion on this subject in this country. Abroad the reverse was the case. The alcoholic habit was an endemic disease in this country, and was responsible for an amount of disease and death which it was difficult to appreciate.

**A MEDICAL HERO.**

IT is not necessary to relate to our readers all the occurrences which led to the sad ending of the drama in which the late Dr. William Smyth, of Burtonport, lost his life. The knowledge of these occurrences has been widely distributed throughout the country by letters and paragraphs in the lay press, which have brought vividly home to their readers the nature of the services which he had rendered to his fellow-men. In this matter the lay press have acted with the generous appreciation of acts of heroism which is characteristic of Britons, but they have not, as yet, done quite all that is asked of them. They have thrown a strong light upon Dr. Smyth's services to stricken humanity, by which he met his death. Will they now call attention to the duties his fellow-men owe to his widow and eight orphans? An appeal has been sent forth on behalf of those whom he left behind, and if that appeal is brought generally to the



[Photo. Ayton, Londonderry.]

**A MEDICAL HERO.—THE LATE DR. WILLIAM SMYTH.**

notice of a sympathetic public it will be answered in a manner which will secure the necessary sum of money to provide for Mrs. Smyth and her children, as it is right they should be provided for. Already subscriptions have been sent in to the treasurers of the fund by many well-known men both in England and Ireland, and subscriptions from many more will come, if only the fact that such are required is brought prominently to the notice of the public. We trust that the members of the medical profession will assist in this most deserving object. Subscriptions may be sent to the presidents of the Royal Colleges of Physicians and Surgeons of Ireland. In this connection it may be mentioned that at a meeting last week of the Irish Medical Association, the following resolution was passed:—

“That the Council of the Irish Medical Association desire to express their earnest sympathy with Mrs. Smyth and her family in the irreparable loss they have sustained in the death of her husband, Dr. Wm. Smyth, of Burtonport, who for many years was a member of this Association. They hope that the memory of his fearless and unselfish devotion to duty on the outbreak of typhus among the poor of Arranmore Island, by which his life was sacrificed, will, in some degree, sustain them in their affliction.”

It is understood that the Royal Commission on Arsenical Poisoning, which is presided over by Lord Kelvin, will not resume its sitting until a date approximating to that of the opening of Parliament.

**Correspondence.**

[We do not hold ourselves responsible for the opinions of our correspondents.]

**PREMATURE BURIAL.**

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In your note of November 27th, headed “A New Plea for Cremation,” you observe “that no instance of live burial has yet been established with that completeness of proof which is demanded by scientific investigators before accepting the truth of any assertion. In other words, there is no evidence of any case of premature burial other than that afforded by hearsay or supported by statements that are obviously riddled by fallacies of one kind and another.” What you understand by “completeness of proof,” “scientific investigation,” or “hearsay,” or what are the fallacies you refer to, it is impossible to form any idea from your note. I would remark, however, that to neglect an obvious precaution against danger because there is no “scientific” proof of the danger to be guarded against is not wisdom but insanity. Fancy a man leaving all his windows and doors open at night because, although he had heard of burglaries in the next street, it was only “hearsay,” and he had not “scientific” proof of the facts alleged, &c., &c.

Bishop Butler tells us that probability is the guide of life, but your leader-writer would seem to be quite of a different opinion. Except from “hearsay,” how do we know of the existence of Julius Cæsar, Shakespeare, Napoleon, &c.?

All history is hearsay. Without for a moment insisting that every tale of premature burial is to be depended on, I do assert that from time to time living persons have been mistaken for dead and treated as such, and that this is as certain as any fact in history. If I do not give instances it is not from want of material, but from difficulty of selection. Again, you “suggest that medical science can determine with precision whether a person is dead or alive.” From what I have read I should infer there are cases where medical science can do nothing of the kind; but the point is quite immaterial in view of the common practice of doctors in giving certificates of death without even seeing the alleged dead. What is the use of medical science if doctors do not avail themselves of it?

I am, Sir, yours truly,

HERBERT N. MOZLEY, M.A.,

Barrister of Lincoln's Inn.

East View, Murray Road, Northwood,  
Dec. 4th, 1901.

[The weak logic of the above letter is hardly of the kind that might be looked for in a legally-trained mind. Burglary is a fact established by overwhelming evidence in myriads of cases in courts of law. Our contention is that no instance of premature burial has been proved by evidence that would carry conviction to the minds of a legal tribunal. The danger is therefore not shown to exist otherwise than in the imagination, and it is surely somewhat superfluous to guard against imaginary dangers. The householder who did not protect his house against burglary would be ignoring a well-recognized and established danger. But if, let us say, he were to put bars in his chimney to prevent Santa Claus entering his house in the night he would be providing against an occurrence that is a simple fable, but hardly more so than the suggestion of premature burial. The fallacies of the subject have been duly set forth in a little book by Dr. Walsh (Baillières and Cox). Hearsay may be divided into two classes: hearsay of statements that are founded on fact and will bear sifting, and hearsay of statements that are not supported by fact and will not bear analysis. The evidence brought forward in support of the theory of

premature burial is of the latter order. We suggest that our correspondent, as a lawyer, should carefully investigate the evidence of any cases of premature burial he may find and set them forth in form of a brief.—[Ed.]

#### INSANITARY ANGLES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

Sir,—In this age of the universal provider, "Enquire within upon everything" may soon have to be announced over the entrance to our police-courts. It speaks volumes for the character of our magistrates and the patience of our people that honesty of purpose has so long been accepted when it is patent to all concerned that the instrument of justice is so often wanting in the technical knowledge without which an opinion is as likely to be wrong as right.

When a sanitary inspector of a local authority differs from a qualified and experienced architect or engineer as to the inclination at which a drain should be laid, the Legislature in its wisdom has imposed upon our magistrates the duty of deciding between them, and thus it came about on Friday last that Mr. Curtis-Bennett, at the Marylebone Police Court, decided that a new stone-ware drain, bedded in concrete, proved to be sound and water-tight and thoroughly well-ventilated, should be taken out and reconstructed because he shared the opinion of the sanitary inspector that a pipe at an angle of 90° with the horizontal did not give a suitable fall.

Is this the discovery of an insanitary angle? Or, is it a gross interference with reasonable liberty? Because I constructed a drain with a vertical fall rather than endanger the foundations of the house by putting the drain several feet below them, can anyone seriously maintain that such a drain is, therefore, dangerous to health? If this cannot be maintained, has not the interference of the sanitary inspector reached a stage when some serious stand should be made against it?

I am, Sir, yours truly,

MARK H. JUDGE,

A.R.I.B.A., Fellow Soc. Inst., Associate  
Society of Medical Officers of Health.

7, Pall Mall, December 3rd, 1901.

#### THE VACANCY ON THE STAFF OF ST. BARTHOLOMEW'S HOSPITAL.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR—In your last issue you mention my name as that of a possible candidate for the forthcoming vacancy on the surgical staff of St. Bartholomew's Hospital.

Those who know what happened at the last election for an assistant surgeon, and who are acquainted with the mode of procedure still in vogue on these occasions at this ancient hospital, will not be surprised to hear that I have not the slightest intention of ever again contesting such an election.

The election is in the hands of some two or three hundred lay governors. The acting medical and surgical staff of the hospital have no votes.

On the occasion to which I have referred seventeen out of twenty-one of the staff (as I have been informed by several of their number) supported the claims of one candidate. A majority of the governors gave the post to another.

I am, Sir, yours truly,

JAMES BERRY, B.S.Lond., F.R.C.S.,  
Surgeon to the Royal Free Hospital; formerly  
Surgical Registrar and Demonstrator (successively) of Anatomy, of Operative Surgery, and of Practical Surgery at St. Bartholomew's Hospital.

Wimpole Street, W., December 9th, 1901.

#### Death under Chloroform.

A MAN, aged 25, was anaesthetised by the aid of chloroform at the Birmingham Ear and Throat Hospital last week, for the purpose of removing a post-nasal polypus. After the operation he suddenly became collapsed and died.

## Medical News.

#### Small-pox in Philadelphia.

A LARGE increase in the number of small-pox cases is reported from the United States. In Philadelphia alone over 120 deaths are reported to have taken place during last month.

#### The Macclesfield Infirmary Dispute.

WE have received from the Hon. Secretary of the Manchester Medical Guild the following resolution, which was passed at the last meeting of the Council of the Medical Guild on Friday last:—"That the Council of the Manchester Medical Guild approves of the attitude of the honorary medical staff of the Macclesfield Infirmary in the present dispute with the governing committee, in contesting the right of lay boards to appoint house surgeons in opposition to the wishes of the honorary staff, and hopes that they will receive the unanimous support of the honorary consulting surgeons and of the whole profession."

#### A Medical Club in Paris.

A MEDICAL club has recently been founded in Paris at No. 5, Avenue de l'Opéra, in premises belonging to the Cercle National. Its object is to promote friendly relations among its members, to form a professional centre for the medical practitioners of Paris, and to provide the advantage of a club for provincial and foreign doctors visiting Paris. Visitors will be able to obtain at the club all the information they may require as to lectures, hospital visits, scientific and medical societies, &c. Professor Pozzi is the president, and Dr. Doléris the secretary-general of the club. The medical profession of Brussels is also, we learn, thinking of founding a club.

#### Dublin Death-rate.

IN the Dublin registration area the deaths registered for the week ending Saturday, November 30th, 1901, represent an annual rate of mortality of 19.6 in every 1,000 of the population. During the 48 weeks ending with Saturday, November 23rd, the death-rate averaged 25.7. Thirty-six of the persons whose deaths were registered during the week were infants, of whom 13 were under one month old. In 7 cases the cause of death was uncertified, there having been no medical attendant during the last illness.

#### National Association for the Prevention of Tuberculosis.

A MEETING of the Executive Committee of the Dublin Branch was held last week at the Royal College of Physicians, Sir John W. Moore, M.D., in the chair. The Committee had under consideration the Registrar General's Annual Report of Marriages, Births, and Deaths in Ireland for the year 1900, but in particular his statement of figures with regard to tuberculosis. From these it appears that among diseases tuberculosis stands highest as a cause of mortality, and claimed 12,848 victims during 1900; 10,076 deaths were due to pulmonary tuberculosis; 1,026 to tabes mesenterica; 749 to tuberculous meningitis; and 997 to other forms. The total deaths from tuberculosis represent a rate of 2.88 per 1,000, being 0.03 per 1,000 in excess of the previous year. The rate from pulmonary tuberculosis is 2.26 per 1,000 living. The phthisical death-rate in the four provinces reads thus: Leinster, 2.50; Munster, 2.32; Ulster, 2.24; and Connaught, 1.62 per 1,000. The increase of tuberculosis in Ireland is shown by the following returns, which do not confirm the statements that sometimes appear in regard to the decrease of this scourge in Ireland. The rates per 1,000 of estimated population are:—Average for ten years, 1871-80, 2.6; average for ten years, 1881-90, 2.7; average for nine years, 1891-9, 2.8; average for twenty-nine years, 1871-90, 2.7; 1900, 2.9. The want of any accommodation, practically speaking, for advanced consumption other than in the workhouse infirmaries in Ireland, accounts for the following results in the unions:—In the North Dublin Union the death-rate from tuberculosis was 5.7 per 1,000; in the South Dublin Union it



was 5.5; in Belfast, 4.4; in Londonderry, 2.9; in Waterford, 3.6; and in Limerick, 3.4. The hon. secretary was directed to draft a letter to the Public Health authorities, to be submitted for consideration at the next meeting of the Committee, in reference to a more full adoption of the notification of tuberculosis.

#### The Medical Sickness and Accident Society.

THE usual monthly meeting of the Medical Sickness, Annuity, and Life Assurance Society was held on the 29th ult., at 429, Strand, London, W.C. There were present Dr. de Havilland Hall, in the chair; Dr. J. B. Ball, Dr. Walter Smith, Mr. H. P. Symonds, Mr. William Thomas, Mr. F. S. Edwards, Dr. J. W. Hunt, Dr. W. Knowles Sibley, and Dr. Fredk. S. Palmer. The record of the Society for the summer months of this year has been very satisfactory. The sickness claims have been light, and the rate of management expenditure exceedingly low, with the result that a substantial addition has been made to the funds of the Society. The number of new entrants has also been greater than in the corresponding period of last year, and as no expenditure is ever incurred in the nature of advertisement, the committee hope that the appeal they have so often made to the existing members to help them in extending the business is now bearing fruit. The number of those permanently incapacitated remains about the same, but one or more additions to this list are expected shortly. Such members draw usually one hundred guineas a year, and special reserves are made to secure this valuable benefit to those entitled to it. Prospectuses and all particulars on application to Mr. F. Addiscott, Secretary, Medical Sickness and Accident Society, 33, Chancery Lane, London, W.C.

#### The Housing Problem.

THE question of the housing of the working classes is commanding a great deal of attention at the present time, and the illustrated article in the December number of the *Studio*, describing Mr. George Cadbury's successful solution of the difficult problem at the village of Bournville, near Birmingham, will be read with considerable interest, and doubtless materially assist where such a solution is possible. But villages are not found on the outskirts of London, and it is here the difficulty presents insuperable obstacles.

#### St. Thomas's Hospital.—House Appointments.

The following gentlemen have been selected as house officers for the ensuing term:—House physicians—L. H. C. Birkbeck, B.A., M.B., B.Ch., Oxon. (extension); V. S. Hodson, B.A., M.B., B.Ch., Oxon. (extension); W. M. G. Glanville, B.A., M.B., B.Ch., Oxon.; and T. W. S. Paterson, M.A., M.B., B.C., Cantab., L.R.C.P., M.R.C.S. Assistant house physicians—T. B. Henderson, M.A., M.B., B.Ch., Oxon., and H. S. Stannus, L.E.C.P., M.R.C.S. House surgeons—C. A. R. Nitch, M.B. Lond., L.R.C.P., M.R.C.S.; W. H. O. Woods, B.A., M.B., B.C., Cantab.; S. Hunt, L.E.C.P., M.R.C.S.; A. S. Grimwade, L.R.C.P., M.R.C.S. (all extension). Assistant house surgeons—G. A. C. Shipman, M.A., M.B., B.C., Cantab., L.R.C.P., M.R.C.S.; W. Hill, B.A., Cantab., L.R.C.P., M.R.C.S.; T. W. H. Downes, L.R.C.P., M.R.C.S.; F. J. Child, M.A., M.B., B.C., Cantab., L.R.C.P., M.R.C.S. (all extension). Obstetric house physicians—(Senior) Z. Mennell, M.B., Lond., L.R.C.P., M.R.C.S.; (junior) H. T. D. Acland, L.R.C.P., M.R.C.S. Clinical assistants in the special department for diseases of the throat—A. D. Hamilton, L.R.C.P., M.R.C.S. (extension), and A. P. Bowdler, B.A., Cantab., L.R.C.P., M.R.C.S.; (skin) F. Clarkson, M.B., B.S., Durh. (extension), and J. L. Timmins, M.A., B.C. Cantab., L.R.C.P., M.R.C.S. (extension); (ear) F. Clarkson, M.B., B.S., Durh. (extension). Electrical department—L. S. Dudgeon, M.R.C.P., M.R.C.S.

#### The Irish Hospital Corps.

HIS EXCELLENCY THE LORD LIEUTENANT publicly presented war medals, on Saturday last, to the members of the Irish Hospital Corps who recently returned from Africa, where they had rendered most conspicuous service. The ceremony took place in the Upper Castle Yard, and His Royal Highness the Duke of Connaught was among those present.

His Excellency, before presenting the medals, made a short speech, in the course of which he said that it was the privilege of the illustrious medical profession that the career of its members was occupied not only in securing their own advancement and success, but in alleviating the sufferings and ministering to the wants of others who stood in need of those services, and at no time are those services so valuable as in the time of war. The spirit in which the members of the medical and surgical professions had performed their duties had been, from time immemorial, one which had earned for them the gratitude and respect of their countrymen. He then alluded to the service rendered by the late Sir William MacCormac during the war, and to that pathetic history of the self-denying work which was performed by Dr. Smyth, of Burtonport, who met his death the other day under such painful and yet under such glorious circumstances. He believed it was the spirit which animated these two great men that impelled his hearers to go over six thousand miles to do what they could to relieve suffering, and to assist their fellow men who are fighting the battles of their country on those distant shores, and he was quite sure he was speaking on behalf not only of his Royal Highness and himself, but also of the whole of their fellow countrymen, when he said that they were grateful to them, that they were proud of them for what they had done, and that the recollection of their services would never be effaced from their memories. Sir W. Thomson then returned thanks. The medals were presented among others to the following:—Sir Wm Thomson, Dr. Stoker, Dr. Coleman, Dr. Friel, Mr. Thomson, Dr. Edwards, Miss M'Donnell, who acted as matron of the hospital; and Miss M'Gonigle, one of the staff sisters.

#### Harveian Society of London.

THE annual dinner of the Harveian Society of London was held on Thursday, November 28th, in the Regent Saloon of the Café Monico. The chair was occupied by Dr. David B. Lees, President, and seventy-seven members and guests sat down to dinner. Amongst those present were:—Sir Thomas Barlow, Sir G. Anderson Critchett, Mr. H. G. Howse, Dr. W. H. Allchin, Mr. Howard Marsh, Mr. Alf. Cooper, Mr. Watson Cheyne, Dr. Dundas Grant, Mr. G. P. Field, Mr. Edmund Owen, Mr. E. Noble Smith, Mr. C. R. B. Keetley, &c. The usual loyal toasts having been proposed by the President (Dr. Lees), Dr. W. H. Allchin, President of the Medical Society, proposed "Success to the Harveian Society," briefly sketching the career of the society from its foundation in 1831, and pointing out the various causes which rendered it such an attractive society. Dr. Lees responded for the Harveian Society. Mr. C. R. B. Keetley then proposed "The Sister Societies" and "Our Guests" in his usual humorous style, drawing a fancy picture of what the profession might become in a few years' time should the members ever adopt trades union principles in their work. Mr. Howard Marsh, President of the Clinical Society, responded for the Sister Societies, and Mr. H. G. Howse, President of the Royal College of Surgeons, responded for the Guests. "The President" was proposed by Mr. E. Noble Smith, Dr. Lees replied, and in his speech proposed "The Honorary Secretaries," to which toast the Senior Secretary, Mr. Hubert C. Phillips, replied. In the intervals between the speeches a selection of excellent music was rendered.

#### Pass Lists.

##### Royal Colleges of Physicians and Surgeons, Ireland.

THE following candidates have passed the examination for the Diploma in Public Health:—Ulrick Joseph Bourke, Lt.-Col. R.A.M.C.; Michael James Bodkin Costello, M.B., B.Surg., B.U.I.; Hampton Atkinson Dougan, M.B., B.Ch., Univ. Dubl.; Digby Patrick French, L.R.C.P. and S.E.; Alfred Moore, M.D. Univ. Dubl.; John Henry M'Anlay, L.R.C.P. and S.E.; Caleb James Powell, L.R.C.P. and S.I.; Charles Lane Sansom, F.R.C.S. Edin.; Robert Fox Symons, L.R.C.P. Lond., M.R.C.S. Eng.

## Notices to Correspondents, Short Letters, &c.

**CORRESPONDENTS** requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

### SUICIDES IN ENGLAND AND WALES.

ACCORDING to the last official returns—those for 1899—3,000 suicides occurred in that year in England and Wales, a large proportion of which are regarded as due to the facility with which poisons can still be obtained by the public. In the same year there were 636 deaths by misadventure, the result of poisoning.

Dr. S. J.—The occasion is not one calling for official representation on our part.

Dr. J.—As a registered practitioner the lady has a right to fair play *qua* treatment on terms of equality. The exercise of that right, however, still calls for prudence, tact, and judgment, but these qualities are necessary on the part of all concerned.

### ANTI-BACTERIOLOGICAL INGENUITY.

AN amusing incident is reported from Queensland in connection with an attempt, on the part of a local bacteriologist, to import some microscopic slides of plague bacillus. The Customs authorities were strongly adverse to their entrance, but were at a loss to adduce legal warrant for such action until it occurred to one of them that the slides in question were put up in gelatine, which is a dutiable article, liable to seizure and confiscation upon non-declaration. This served as a pretext for the prompt destruction of the bacillary slides. It is a pretty story, but we do not see where the gelatine came in, it not being utilised for the purpose of mounting specimens. Moreover, bacilli embedded in Canada balsam, which was presumably the excipient used, are necessarily as dead as Queen Anne and fully as innocuous. However, it seems a pity to subject so circumstantial an anecdote to hostile criticism.

Mr. T. D. S.—Regret we are unable to publish your communication; it is unsuitable for our columns.

M.D. (Edinburgh).—Your communication is unavoidably crowded out; we hope to have space in our next.

Mr. MORNINGTON. Letter arrived as the journal was "at press."

### POST-DIVORCE MORTALITY.

GERMAN statistics on the death-rate among divorced persons reflect unfavourably on their longevity. Dr. Morrell states that there are, in Prussia, 348 cases of suicide among women who have been divorced, as against 61 married women, per million of population. In regard to men the proportion is even higher, viz., 2,834, as against 286 among married men.

QUESTOR. Fresh parsley, chewed after eating onions, and bulbs of that class is reputed to annul the alliaceous odour thereof, but there is no reason to suppose that the effect would be the same in respect of the emanations resulting from the ingestion of cacodylate of sodium.

## Meetings of the Societies, College Lectures, &c.

### LONDON.

WEDNESDAY, DEC. 11TH.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—5 p.m. Mr. T. B. Jessop: Personal Experiences in the Surgical Treatment of Certain Diseases. (Bradshaw Lecture.)

DERMATOLOGICAL SOCIETY OF LONDON (11, Chandos Street, Cavendish Square, W.).—5.15 p.m. Demonstration of Cases of Interest.

SOUTH-WEST LONDON MEDICAL SOCIETY (Bolingbroke Hospital).—Paper:—Dr. A. E. Giles: Diagnosis of Pelvic Tumours.

THURSDAY, DEC. 12TH.

CHILDHOOD SOCIETY (Library of the Sanitary Institute, Margaret Street, W.).—8 p.m. Lecture.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM (11, Chandos Street, Cavendish Square, W.). Clinical Evening. Cases will be shown by Mr. H. W. Dodd, Mr. H. Juler, Mr. E. T. Collins, Mr. S. Stephenson, Mr. G. B. James, Mr. G. Keeling, Mr. J. B. Lawford, Mr. G. W. Roll, Mr. J. H. Fisher, and Mr. L. V. Cargill.

BRITISH GYNÆCOLOGICAL SOCIETY (20, Hanover Square, W.).—8 p.m. Specimens will be shown. Paper:—Mr. S. Bishop: A Demonstration of Some Changes Observed in Uteri the Seat of Fibromyomata.

FRIDAY, DEC. 13TH.

CLINICAL SOCIETY OF LONDON (20, Hanover Square, W.).—8.30 p.m. Papers: Dr. Habershon: The Association of Movable Kidney on the Right Side with Symptoms of Hepatic Disturbance. Dr. S. Wilson: The Theory of Compensation in Disease of the Mitral Valve. Dr. W. H. White and Dr. W. C. Pakes: A Case of Malignant Endocarditis giving Widal's Reaction. Mr. E. P. Paton: A Case of Hair Ball removed from the Stomach of a Child nine years.

EPIDEMIOLOGICAL SOCIETY (11, Chandos Street, Cavendish Square, W.).—8.30 p.m. Paper:—Dr. Mott: Dysentery in Asylums.

### DUBLIN.

THURSDAY, DEC. 12TH.

Council Meeting, Royal College of Surgeons.

FRIDAY, DEC. 13TH.

Royal Academy of Medicine in Ireland. Medical Section (Royal College of Physicians)—8.30 p.m. Exhibits:—1. Dr. Finny: A Case of Disseminated (Insular) Sclerosis in a girl aged 20. 2. Dr. W. J. Thompson: A Case of Obscure Abdominal Tumour. Papers:—1. Dr. George Peacocke: Hemichorea and Parotitis complicating a Case of Diabetes. 2. Dr. W. E. Dawson: Glycosuria and Insanity (Clinical Study). 3. Dr. J. M. Day: The Diagnosis of Scarlatina. 4. Dr. J. J. Burgess: A Case of Extreme Fatty Infiltration of the Right Ventricle with Acute Pericarditis and Hemorrhage into the Pericardium.

## Appointments.

CHOYCE, CHARLES C., M.B., Ch.B. Edin., B.Sc. New Zealand, House Physician to the Leicester Infirmary.

DUNCAN ANDREW, M.D. B.S. Lond., M.R.C.P., F.R.C.S., Physician to the Westminster Dispensary.

GOUGH, H. E. M.R.C.S., L.R.C.P. Lond., Medical Officer of Health for the Rural District of Northwich.

HARVEY, FRANK, M.R.C.S., L.S.A., Medical Officer of Health for Padstow, Cornwall.

LOW V. WARREN, F.R.C.S., Surgeon to Out-patients at the Great Northern Central Hospital, Holloway.

MARR, H. C., M.D. Glasg., Medical Superintendent at Woodilee Lunatic Asylum, Lenzie, N.B.

O'CONNOR, J. E., M.B., B.S., B.U.I., D.P.H. Camb., Medical Officer of Health for the combined districts of Leicestershire, Rutland, and Warwick.

PARRY, LEONARDA, F.R.C.S., B.S., M.D. Lond. Assistant Surgeon to the Royal Alexandra Hospital for Children, Brighton.

SINCLAIR, NORMAN J., M.B., Ch.B. Aberd., Medical Officer of Health and Police Surgeon for the Burgh of Brechin.

SMART, WALTER, F.R.C.S.I., L.R.C.P.I., Medical Officer and Public Vaccinator of the Tarpoley District of the Tarna Union (Cheshire).

THOMSON, B., M.R. Glasg., Assistant Medical Officer of the Holborn Infirmary at Highgate.

WYNTER, WALTER ESSEX, M.D. B.S., F.R.C.S., F.R.C.P., Physician to the Middlesex Hospital.

## Vacancies.

Bethlem Hospital.—Two Resident House Physicians recently qualified in Medicine and Surgery. Term six months from January 1st next. Apartments, complete board, and washing provided, and an honorarium at the rate of £25 each per quarter will be paid. (See Advt.)

Buxton, Devonshire Hospital. House Surgeon and Assistant House Surgeon. Salary, House Surgeon £100 per annum. Assistant House Surgeon £50 per annum, with furnished apartments, board, and lodging in both cases. Full particulars on application to the Secretary.

Clifden Union, Medical Officer. Salary £150 per annum, and £10 a year as Medical Officer of Health, together with the usual registration and vaccination fees. Applications to F. King, Clerk of Union. (See Advt.)

County Asylum, Rainhill, near Liverpool.—Assistant Medical Officer. Salary commencing at £150 per annum, with apartments, board, attendance, and washing. Applications to the Medical Superintendent.

Down District Lunatic Asylum.—Assistant Medical Officer. Salary commencing at £150 per annum, with board, apartments, washing &c. Applications to be addressed to the Resident Medical Superintendent. (See Advt.)

Middlesex Hospital.—Assistant Physician on the honorary staff. Forms of F. Clare Melhado, Secretary Superintendent.

Nottingham General Hospital.—House Surgeon. Salary commencing at £100, rising to £120, with board, lodging, and washing. Applications to the Secretary.

Rochdale Infirmary.—Resident Medical Officer. Salary £100 per annum, with board, residence, and washing. Applications to B. W. Shaw, Esq., Southfield, Rochdale.

## Births.

GILBERTSON.—On Dec. 8th, at Southbourne, Hants, the wife of William Gilbertson, M.A., M.D., of a daughter.

MONTGOMERY-SMITH.—On Dec. 4th, at 36, Abbey Road, St. John's Wood, W., the wife of E. C. Montgomery-Smith, M.R.C.S., L.R.C.P., of a son.

SAVERY.—On Dec. 2nd, at 4, Mount Park Road, Ealing, the wife of Frank Savery, M.R.C.S., L.R.C.P., of a daughter.

WILSON.—On Dec. 3rd, at Elstree Cottage, Buahey Heath, Herts, the wife of Daniel Wilson, M.A., M.D., of a son.

## Marriage.

MACKENNA-BIRD.—On Dec. 3rd, at St. John the Evangelist's, Edinburgh, Robert William Mackenna, M.A., M.B., B.Ch. Edin., of Liverpool, second son of Rev. Robert Mackenna, M.A., of Dumfries, to Harriet A. S., youngest daughter of the late Rev. Charles E. Bird, M.A., Rector of Castle Eden, and Rural Dean of Easington.

## Deaths.

ACKLAND.—On Dec. 7th, at Fairhaven, Cornwall, Sophia Dillon, widow of W. H. Ackland, M.D., J.P., late of Bideford, in her 80th year.

HARVEY.—On Dec. 1st, at Simla, Surgeon-General Robert Harvey, C.B., D.S.O., F.R.C.P., LL.D., Director-General of the Indian Medical Service, eldest son of the late Dr. Alexander Harvey, Regius Professor of Materia Medica in the University of Aberdeen.

# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXIII.

WEDNESDAY, DECEMBER 18, 1901.

No. 25.

## Original Communications.

### TRAUMATIC ULCER OF THE CORNEA. (a)

By A. MAITLAND RAMSAY, M.D.,

Surgeon to the Glasgow Ophthalmic Institution, Professor of Ophthalmology in St. Mungo's College and Lecturer on Diseases of the Eye in Queen Margaret College, University of Glasgow.

AMONG artisans the commonest accident to the eye is that where a minute particle of metal becomes embedded in the corneal epithelium. The workmen themselves speak of such a foreign body as a "fire," and the term is not inappropriate, because as a rule the body is at a white heat when it flies from the tool. When it reaches the eye therefore it burns its way into the tissues, but as the heat has rendered it aseptic it rarely brings about any serious damage to the cornea. Its presence, however, gives rise to so much suffering that the patient is naturally desirous to have it removed at the earliest possible moment, and as often as not appeals to a fellow-workmen for help. Unskilful attempts at extraction are unfortunately always more harmful than the "fire" itself, which, if left alone, becomes surrounded almost at once by an army of leucocytes. These immediately begin to manufacture a special ferment, which acts upon the tissues in such a manner that a whitish ring of softened epithelium forms round the foreign body, and in two or three days this loose tissue separates from the parts beneath, and the metallic particle is carried off in the slough. In this way a superficial ulcer of the cornea is formed, but the breach of surface rarely causes any trouble, and is, in a remarkably short time, covered over by a new growth of epithelium.

There is, however, no accident to the eye which is so trivial that it can be safely neglected or left to unskilled treatment. Whenever a foreign body is removed from the eye the patient experiences an immediate sense of relief, and, as a rule, nothing more requires to be done than to bathe the conjunctival sac with boracic lotion, to apply cocaine ointment if the pain continues, and to adjust a compress and bandage, with instructions that they must be worn until all signs of irritation have disappeared. Lotions containing acetate of lead are deservedly popular in the treatment of conjunctival inflammations, but they must never be used when there is the slightest abrasion of the cornea, for under such circumstances the acetate is decomposed, and a precipitate of white lead is deposited over the ulcer. Numerous instances might be cited of permanent damage to the eye following the use of a sugar of lead lotion. Quite recently I was consulted by a gentleman over the surface of whose right cornea

there was a white cloud, which seriously impaired its transparency, and dimmed the sight so greatly that fingers could not be counted when held more than three or four feet away from the eye. The patient told me that three months previously, as he was entering a room in which he kept a pet canary, the bird flew to meet him, and accidentally struck his right eye with its claw or beak. It is not certain whether the cornea was actually scratched at the time of the accident, but there was a minute cut at the margin of the upper lid, and an eyelash had been driven into the wound in such a way that with every act of winking it rubbed against the cornea. The irritation this induced occasioned intense suffering, and as the cause of it had been overlooked and only momentary relief was obtained from the use of the remedies prescribed, the gentleman, who was a pharmaceutical chemist, took the treatment of his case into his own hands, and sent to his shop for an ointment containing carbolic acid, acetate of lead and cocaine. A more mischievous combination could hardly have been imagined, for no sooner was it applied to the eye than the sight, which had up to that moment been unaffected, suddenly became dim and the cornea was observed to have lost its transparency owing to a deposit of white lead having taken place over its surface. As such an opacity is indelible, vision is permanently lost. What, in this case, had it been properly attended to, would have been a most trivial accident, terminated in serious disaster.

The greatest danger to the eye, however, after an abrasion of the cornea is the risk of infection of the wound. Micro-organisms, some of which may be pyogenic, are always lurking in the conjunctival sac, but as long as the epithelium remains intact they do no harm. The corneal epithelium forms an insuperable barrier to the entrance of germs, but let it be abraded ever so little and at once micro-organisms find their way through the breach of surface and invade the tissues. This infection may occur at the time of the accident or may take place later from inoculation of the wound by secretion from the conjunctiva from diseased tear passages or from the nasal mucous membrane. In the presence of discharge from a blennorrhœa of the lachrymal sac an abrasion of the cornea is almost certain to suppurate, and it is well known that to operate upon the cornea under such circumstances is simply to court defeat. Naturally, suppuration is much more likely to occur in old and poorly-nourished subjects, or in those whose tissues have been rendered vulnerable as a result of alcoholic or other excesses; and in considering the ætiology of suppurative keratitis the predisposition of the patient must be taken into account equally with the infecting micro-organism. Unless that be granted the explanation of those cases of suppuration which run a peculiarly fulmi-

(a) A Post-graduate Lecture delivered in the Glasgow Ophthalmic Institution on November 12th, 1901.

nating course would be a matter of extreme difficulty. The following is an example: J. C., *et. 56*, was playing with a cat when it accidentally inflicted a slight scratch in the right cornea and the edge of the lower lid. Three days afterwards he was brought to the Ophthalmic Institution, and on admission it was found that the whole cornea had suppurated; there was pus in the anterior chamber, and owing to intense orbital cellulitis there was marked proptosis and chemosis of the ocular conjunctiva, while the skin over the eyelids, forehead, and cheek was so red and inflamed as to raise the suspicion that the appearance might be due to erysipelas. Numerous pyogenic organisms were found in cultures taken from the cornea, but there can be no doubt that the peculiarly virulent course followed in this case was largely determined by the fact that the patient's tissues had been rendered peculiarly vulnerable by a lifetime's indulgence to excess in alcohol. In all cases where such rapid and complete suppuration of the cornea occurs, probably the wisest treatment is to eviscerate at once, and so save the patient the severe and protracted suffering always attendant upon an attack of panophthalmitis.

Associated with the presence of the pneumococcus is a form of ulceration of the cornea to which the name *serpiginous ulcer* has been given. Although one of the most dangerous diseases of the eye it usually follows a very trivial injury. A miner or a stone-breaker gets his eye struck by a piece of coal or of stone, but so little does he think of it that he continues at his work; a mother while nursing and playing with her child receives a tiny scratch in the cornea from the infant's finger nail; an artisan, with a fire in his eye, gets the corneal epithelium abraded by the clumsy attempts of a companion to remove the foreign body with the point of his pocket-knife. Such accidents, most trivial in themselves, and consisting of nothing more than a breach of the corneal epithelium, may lead to most disastrous consequences if the wound becomes infected by the pneumococcus. This form of ulceration attacks adults for the most part, and as the virulence of the micro-organism seems to be favoured by hot weather, some of the very worst cases are seen among agricultural labourers whose eyes have been injured in the harvest field. The ulcer is usually situated towards the centre of the cornea. It is somewhat crescentic in shape, and while its floor shows only a shallow depression, rough and glistening, its margins are opaque, raised, undermined and suppurating. One of the most striking characteristics of this ulcer, and that from which it derives its name, is the tendency it has to creep over the surface of the cornea, but while progressive in one direction it usually tends to cicatrize along the opposite border, although in some cases it spreads with such intense rapidity that the whole cornea may be eaten away in a few days. Its peculiarly infective nature may be early diagnosed by its extreme painfulness, by the occurrence of deposits in Descemet's membrane, and by the formation of pus in the most dependent parts of the aqueous chamber, while corresponding with these there are always more or less intolerance of light, injection of the conjunctival and ciliary blood vessels, and swelling of the lids. The early involvement of the deeper parts of the cornea leads to inflammation of the iris, and with the occurrence of iritis there is always an increase in the hypopyon.

The researches of Leber have thrown considerable light upon the pathology of serpiginous ulcer. As a result of experiment he has shown that when the cornea is inoculated with micro-organisms the toxins they manufacture are speedily carried by diffusion to the surrounding parts, and an irritant

action is set up in blood-vessels at a considerable distance from the original seat of infection. The process is analogous to that induced by the diffusion of a chemical poison, and as a result the circumcorneal vessels become dilated, and there is a rapid migration of white blood corpuscles through their walls. These leucocytes quickly force their way through the cornea to reach the spot where the microbes are most active. The nearer they approach this, however, the more intense becomes the action of the toxins, and at length overpowered by the poison many perish and form a purulent zone round about the ulcer, while those which survive enter the microbic area to wage war against the germs. According to this view the cornea is perfectly passive, and the leucocytes wander through it at will, to overcome the action of the microbes, or to be themselves overcome and meet their death by poisoning in the neighbourhood of the infected area. But the cornea is not a passive agent in this process; on the contrary, it is intensely active, and its protoplasmic elements respond at once to the very slightest irritation. Throughout every part of the substance of the cornea are corpuscles, united the one to the other by thread-like prolongations, so that in its essence the cornea may be regarded as a sheet of protoplasm, and consequently one of the most vital structures in the body. Under ordinary circumstances these corpuscles proliferate and multiply to provide for the growth and maintenance of the corneal tissue, so it is not surprising to find that under the increased stimulation brought about by disease this physiological process becomes greatly exaggerated. No one has investigated this subject with greater care than Dr. Thomas Reid, and he has demonstrated that this process of proliferation of the fixed corneal corpuscles begins almost from the very moment of the injury, and in a specimen he obtained enucleated twenty-four hours after the occurrence of an abrasion, this new development of protoplasm extended throughout the entire thickness of the cornea, and even at this early period there were signs of exudation in Descemet's membrane associated with proliferation of its endothelial cells. Dr. Reid's microphotographs also demonstrate that at a later stage the protoplasm gets broken up and filled by round bodies which bear no resemblance to leucocytes on the one hand, or to the original nuclei of the corneal corpuscles on the other. Whatever they may be, they seem to be the result of an expiring effort on the part of the protoplasm to restore injured tissue before the corpuscles become completely destroyed. It appears probable therefore that, coincident with the migration of leucocytes, there is also proliferation of the fixed corneal corpuscles, the one to protect the cornea from the invasion of the microbes, the other to repair the structural damage which the micro-organisms have induced.

The irritant action of the toxins extends deeply as well as superficially, so in addition to the changes already described as occurring in the circumcorneal vessels, those of the iris and ciliary body are implicated very early in the course of a serpiginous ulcer. It is this action of the toxins upon the highly vascular uveal tract that in great part determines the occurrence of hypopyon. Formerly it was believed the pus in the anterior chamber came direct from the ulcer through a perforation in Descemet's membranes, but that at least is not a full explanation, because in some instances pus can actually be seen rising up from behind the iris and entering the aqueous through the pupil. Moreover, if in all cases there was direct communication between the ulcer and the hypopyon, one would expect to find in the latter micro-organisms similar in kind to those present in the former. Such, however, is

rarely the case, for if in the early stages the pus in the anterior chamber be examined bacteriologically, no micro-organisms are found, and such a negative result can only point to the conclusion that hypopyon is due, in its beginning at least, to the irritant action of toxins rather than to the presence of the micro-organisms themselves. In many cases, also, and especially during the early periods of the disease, the pus in the anterior chamber is intimately mixed with fibrinous exudation which can be derived only from the blood-vessels of the iris and ciliary body. Clinical experience also lends support to this view of the case. In hypopyon ulcer, where the exudation into the anterior chamber is so plastic that it does not flow out after paracentesis but requires to be removed by forceps from the lips of the wound in the cornea, the prognosis is usually more favourable than it is when the pus is quite fluid, varying in amount from day to day, and emptying itself completely after an opening has been made into the aqueous chamber. I have never been able to demonstrate it, but I think it is very probable that in the latter cases a rupture has taken place in Descemet's membrane, whereby the micro-organisms have gained entrance to the interior of the eye, and have inoculated the hypopyon, which they have liquefied by their action upon the fibrin intermingled with the pus cells.

If left to itself, serpigynous ulcer from its very nature progresses steadily until at length the cornea gives way, and in the most virulent cases the micro-organisms finding a soil suitable for their propagation in the uveal tract and the vitreous speedily set up such intense inflammation that every tissue in the eye-ball is involved. Happily, however, pan-ophthalmitis is now-a-days not a common sequel to hypopyon ulcer, for in many cases perforation of the cornea is the turning point in the course of the disease, and recovery may be said to begin from the time of its occurrence. The prognosis of serpigynous ulcer is, however, always serious, for even where early perforation brings with it arrest of suppuration before the cornea has been extensively destroyed, a dense white scar remains, and as this is usually situated in front of the pupil, sight is seriously impaired, and can only be imperfectly restored by operation. There is, moreover, another source of anxiety. If pyogenic micro-organisms gain admission to the eyeball their presence causes danger not only to the eye primarily attacked, but also to its fellow, which, from the intimate and peculiar nervous and vascular connection existing between the two eyes, is liable to suffer from sympathetic ophthalmitis. Whenever, therefore, the cornea has been destroyed so completely as to preclude all hope of restoring sight the wisest treatment is to enucleate with as little delay as possible.

The most important indications for the treatment of serpigynous ulcer are to keep the eye at rest, to protect it from further injury, and to relieve pain. The patient ought to be kept in bed and all bright light excluded from the room, and the eyelids should be closed by a bandage, which keeps the part at rest, and so promotes healing. In order that the bandage may lie smoothly, and not exert unequal pressure, the hollows at the inner canthus and beneath the orbital margin should be filled up carefully with cotton wool. This ought never to be neglected: a bandage carelessly applied is worse than useless. When there is discharge from the lachrymal sac means must be taken not only to arrest it, but also to keep the tear-passages clear. As iritis is a constant complication in serpigynous ulcer atropine must be instilled from the very outset; locally, it soothes the nerves and diminishes vascular congestion, while by dilating the pupil and paralyzing

the ciliary muscle it ensures physiological rest for the eye. The effect of atropine upon the pupil is one of the safest guides in prognosis, for the more quickly the iris responds to the influence of the mydriatic, the more favourable will be the course of the disease. When pain is acute and there is much congestion of the iris the good effect of the atropine is greatly increased by the application of leeches. In the early stages, free bleeding from the temple always does good, at least for the time being, and in many cases brings about a favourable turn in the course of the disease. Three to six leeches may be applied round the outer canthus, a Heurteloup's artificial leech can be employed. In either case, free bleeding from the wounds should be encouraged. It often happens that after leeching the pupil begins to dilate, although before the blood-letting it had remained persistently contracted. The atropine, in a 1 to 2 per cent. solution, should be instilled three or four times a day, but it must not be forgotten that this drug acts on some persons as an irritant, producing redness and swelling of the eyelids, accompanied by an eczematous eruption of the skin in the neighbourhood of the eye, and at the same time, especially the old and feeble, it may cause acute delirium. Such instances, however, are nothing more than idiosyncrasies of which it is necessary to be aware, so that when they do occur the atropine may at once be stopped and another mydriatic substituted. When the ulcer is about to perforate, the use of eserine is preferable to that of atropine, but with this exception, the former drug has, in serpigynous ulcer, a very limited sphere of usefulness, and almost invariably it is the latter which should be employed. To avoid accidents, however, care ought to be taken to guard against any of the solution finding its way into the mouth, and while it is being instilled the lid should be drawn well away from the eyeball, and pressure applied over the inner canthus to prevent absorption by the tear passages. Moreover, when the patient is to use the drug himself it is safer to prescribe it the form of an ointment or of tabellæ, rather than of a liquid.

The liquid extract of belladonna applied to the brow will sometimes cause the pupil to dilate when instillations of atropine have failed. When the irritation is very severe, and there is much periorbital congestion, great benefit is obtained from the application of fomentations. Moist heat, by diminishing the engorged state of the blood vessels and thereby reducing intra-ocular tension, speedily relieves pain, but just as with bandages a fomentation to be effective must be properly applied, and it must be repeated every two or three hours. It may be made more soothing by the addition of Battley's sedative solution of opium, or by an infusion of chamomile flowers.

If, however, in spite of the above treatment the ulcer continues to progress, a knowledge of its pathology affords the clue to its further treatment. Disinfectants must be applied to its surface. The eye should be freely irrigated by a hot saturated solution of boracic acid until all discharge has been washed away and the floor of the ulcer made as clean as possible; then a powder composed of equal parts of iodoform and boracic acid very finely triturated ought to be dusted freely over its surface. Many other disinfectants have been recommended, the most satisfactory being a collyrium of chinol, 1 in 4,000, and protargol in a 5 per cent. solution. Some advocate the use of subconjunctival injections of solutions of mercurial salts, but my own experience of this form of treatment of serpigynous ulcer is not such as to warrant one in expressing a strong opinion in its favour.

In addition to these local means, general constitu-

tional treatment is always required. The patient must be well fed, and, if old and weakly, a small quantity of alcohol should be given with meals, malt liquors, if they do not disturb digestion, being preferable to any other form of stimulant. The drugs most to be relied upon are quinine in full doses, and opium, administered by the mouth or morphia by hypodermic injection.

If, in spite of the above means of treatment, the ulcer continued to spread there was till a recent period nothing further for the surgeon to do except to stand by and watch the disease pursue its disastrous progress. Saemisch, of Bonn, was the first to alter this condition of things by advocating a bold incision of the cornea through the ulcer, both the puncture and the counter-puncture being made in sound tissue. He treated the eye just as a general surgeon would treat an abscess, and the free incision allowed not only the escape of the hypopyon, but also permitted the drainage of pus held within the corneal lamellæ. The wound should be kept open for several days to allow free drainage. The treatment of hypopyon ulcer, however, is not a parallel to the problem presented to the surgeon in an ordinary abscess, and Saemisch's incision has the obvious disadvantage of allowing the iris to become extensively adherent to the wound in the cornea. Nevertheless the method which he introduced has saved sight to many eyes which would under former conditions have become wholly blind. Since the introduction of the cautery, however, Saemisch's incision is only applicable to cases where the ulceration is very extensive, and where perforation of the cornea appears imminent. Whenever, after twenty-four hours of medical treatment, the ulcer shows no signs of improvement the cautery should be applied without delay. Under such circumstances the only hope of arresting the disease lies in the destruction of the infiltrated spreading edge of the ulcer. To be of any service, however, the cautery must be applied thoroughly, and as the infection of the cornea extends beyond the apparent margin, no operation should be attempted until the boundaries are demarcated by instilling an alkaline solution of fluoresceine. This drug maps out the area of the ulcer by a bright green line, which serves as a guide in the application of the cautery. A fine platinum wire heated to a dull red heat ought then to be applied to the cornea just outside of this green line, and the burning continued until every part of the infiltrated margin is thoroughly destroyed. As the healing of the ulcer will be greatly promoted by the reduction of the intraocular tension, the cornea should be incised at its lower aspect, and the anterior chamber emptied slowly. The evacuation of the aqueous and the hypopyon may be followed by hæmorrhage from the iris, and is always attended by severe pain, owing to the forward displacement of the inflamed iris and ciliary body. If, however, a fomentation be at once applied to the eye, and one-sixth of a grain of morphia injected under the skin of the temple the patient's sufferings are mitigated so much that in a short time he falls asleep for the first time perhaps since the onset of the disease. If the cauterisation has been properly performed the ulcer rapidly begins to heal, and unless any fresh inoculation occur the progress of the case will be uninterrupted until cicatrisation is complete, the resultant scarring being usually much less than would have been anticipated from the extent and virulence of the ulcer. Fresh infection of the ulcer is always accompanied by recurrence of pain, and is in most instances due to carelessness on the part of the patient.

The practical lesson to be learnt from all this is that as it is infection rather than traumatism that brings about serious injury to the cornea, proper

precautions and early attention to all trivial injuries will prevent the occurrence of suppurative keratitis, but if perchance inoculation has occurred and ulceration is progressive, early and thorough application of the cautery is likely to cause its arrest. In the treatment of serpiginous ulcer, once so formidable and intractable, modern ophthalmology has obtained one of its most brilliant successes.

## SOME CLINICAL OBSERVATIONS ON THE TEMPERATURE OF PHTHISIS TREATED BY OPEN-AIR METHODS. (a)

By DR. DAVID LAWSON,

Senior Physician, Nordrach-on-Dee Sanatorium.

THE speaker first described a new graphic method of showing the temperature so as to give a more distinct idea of the course of the case than that generally employed does. The temperature is taken four-hourly, and the highest and lowest readings of each series of four days are averaged, and marked on a chart, each space of which, therefore, represents a period of ninety-six hours. The space between the highest and lowest curves on the chart so obtained is blackened in, and the irregular band of ink thus got gives a better idea of the course of the case than the usual temperature curve. On the same chart the amount of sputum and the body-weight are graphically represented. In the case of an active lesion undergoing arrest the black band is at first broad and, especially on its upper margin, irregular; as improvement takes place, the breadth of the band diminishes, showing less diurnal variation in the temperature, and the band as a whole falls. With this character of the temperature the weight curve rises and the sputum curve falls. It is, of course, necessary to consider all these factors in estimating the progress of a case, and charts were shown illustrating a steady rise of body weight, combined with a broadening and rising temperature band in a fatal case, as well as one showing a gain in weight *plus* a falling temperature in a case which was not progressing favourably. The two features of the temperature of phthisis were its "inelasticity," shown in the resistance with which it remained high under circumstances in which, in a normal subject, it would have fallen to normal, and its "instability" as shown in the excessive daily range, and in the ease with which it rose on trivial provocation. Charts were shown illustrating such points as the rise following on slight excitement after an unexpected visit from a friend, that following gastric disturbance, &c. Dr. Lawson had noticed that during some of the very hot days last summer, rises of temperature were found in nearly all the patients in the Nordrach-on-Dee Sanatorium. After carefully excluding other causes, he concluded that these rises must depend on the external temperature—an example of the "inelasticity" of the temperature of phthisis. He put forward a strong plea for the rectal method of taking temperatures, claiming for it not only greater accuracy, but also that it gave indications of a rise twelve hours before such could be detected in the axilla or mouth. The mouth temperature was easily affected by the swallowing of hot fluids or ice before the thermometer was inserted, and observations on this point were related. When the advantages of the rectal method were frankly laid before the patient he had never found that

(a) Abstract of Paper read before the Edinburgh Medico-Chirurgical Society.

serious objection was raised. Attention was then drawn to some of the common errors of diagnosis due to faulty temperature records, which were liable to occur when only the morning and evening readings were noted, as was often the case in private practice, and, in particular, the speaker remarked on the comparative frequency of the mouse type, which was liable to escape notice unless the thermometer was used during the night. Numerous charts of miliary tuberculosis, typhoid, and phthisis were shown and their bearing on diagnosis discussed. Dr. Lawson then described some of his observations on the effects of exercise on the tuberculous and healthy subject. It was often one of the most difficult things to settle, as well as one of the most important, at what point in the open-air treatment exercise should commence. The dictum had been laid down that absolute quiet should be enforced so long as the temperature at eight a.m. was above 98.6 Fahrenheit. Dr. Lawson had not found this rule by any means absolute, and preferred to take as a guide the course of the temperature after exercise. In a healthy subject the result of active exercise was to raise the temperature one or two degrees, but after the effort was over the temperature fell in less than a quarter of an hour to normal. In tuberculous persons, on the contrary, not only did much less exercise suffice to raise the temperature, but the fall to normal was much more gradual, requiring sometimes an hour or more. His rule was to send the patient out for a walk in the forenoon, returning at twelve o'clock. The temperature was taken then, and unless it was normal at one o'clock, after an hour's rest, the amount done must be restricted, or a further period of complete rest enjoined. In other ways the practical value of the temperature records as guides to treatment was very great, and charts were shown illustrating this. The possibility of complications must always be borne in mind, and he claimed for the rectal method of taking temperatures that it gave earlier and more certain indications of slight disturbances, and therefore gave one a better chance of treating and cutting short these. He regarded the presence of the diazo-reaction as very unfavourable; three out of four cases in which it was prescribed had died, and the fourth was going down hill steadily.

## SUPRA-PUBIC PROSTATECTOMY. (a)

By DAVID WALLACE, F.R.C.S.Ed.,  
Assistant Surgeon, Edinburgh Royal Infirmary.

THE ætiology of prostatic enlargement, the author observed, was as yet obscure; neither age alone, nor the more recently advanced view that it was caused by arterio-sclerosis could explain it, and one was rather driven to the idea that it might have analogies with fibroid tumour of the uterus. It was found in three chief varieties:—(1) Vascular or erectile; (2) fibrotic, usually quite small; (3) fibro-adenomatous, or actual tumour growth in the gland. The four methods of treatment chiefly in vogue were (1) catheter life; (2) cystotomy, perineal or supra-pubic; (3) castration or vasectomy; (4) prostatectomy, perineal or supra-pubic. In early cases, before there was atony of the bladder, and where no complications had arisen, he advised the initiation of catheter life, and if difficulty in catheterisation increased, or if cystitis developed, castration or vasectomy might be employed. These operations had met with considerable success, and statistics were read showing their low mortality. Criticising these, Mr. Wallace said that every

fatal case where death could be ascribed to anything else than operation had been excluded, and hence, practically, the mortality was higher than appeared from them. The operation was quite as severe as cystotomy, and it had this disadvantage, that if the diagnosis was incorrect, *e.g.*, if there should be unsuspected malignant disease of the prostate, it was quite useless. "Prostatism," as the French called it, was a collection of symptoms which might be due to hypertrophy of the organ, or to septic mischief apart from this. The differential diagnosis was often impossible. Rectal examination alone was not sufficient to enable one to decide which was present; measurement of the length of the urethra was a help, but not an absolutely trustworthy one, while cystoscopy was not always practicable. He entered a plea for cystotomy in such cases; if the condition proved to be due to sepsis without enlarged prostate it was the operation of election, while castration, naturally, was useless. The question then came to be whether supra-pubic or perineal cystotomy should be done. He strongly urged the former. Drainage could be as well carried out in this method if Cathcart's modification of Sprengel's pump was used, as in the low operation. Then it had the great advantage that the prostate could be examined and dealt with—either divided or removed—as circumstances might require. The objections alleged were the greater dangers of supra-pubic cystotomy, pre-vesical cellulitis, and the like, but with ordinary care these should not occur. He did not think that the risks of cystotomy were increased when prostatectomy was done. In forty cases of cystotomy he had had four deaths (12.5 per cent.) only one of which was a case in which prostatectomy had been carried out. The fatal cases were as follows:—(1) Palliative cystotomy for vesical cancer; (2) two palliative cystotomies for tuberculous cystitis; (3) septic cystitis, with stricture, for which repeated operations had been performed, and an abscess had formed outside the bladder; (4) prostatectomy. He thought that prostatectomy was specially indicated in fibro-adenomatous enlargement where masses of glandular tissue could be enucleated. Sepsis was no contra-indication; in ten out of his eleven cases there had been cystitis. The operation should be done at one time, not in two stages, because the bladder contracted after it was drained, and there was much greater difficulty in removing the prostate at a second operation. Hæmorrhage was not great, and the risk of permanent fistula was negligible, because if once the urine could escape by a natural passage it would do so in preference to draining through the wound. The bladder should be drained for from one to ten days, according to the condition of the patient, provided it had remained contractile; if there was atony from three to four weeks was required. Mr. Wallace had removed the prostate in eleven patients, whose ages varied from fifty-four to seventy-four years. In five there was enlargement of the middle lobe, in three of the lateral lobes, while hypertrophy of both middle and lateral lobes, circular hypertrophy round the orifice of the urethra, an enlargement of the left lobe was each met with once. Five of these patients were cured, three markedly improved, one temporarily improved, in one it was too early to say how long the improvement would last, while one case (that referred to above) died.

### Accidental Death of a Cardiff Practitioner.

AN inquest was held last week on the body of Edward Christian Hodgson, practising at Cardiff, who was found insensible in an area in Paddington, and subsequently died at St. Mary's Hospital from the effects of a fractured skull. There was no evidence to show how he came there, and a verdict of accidental death was returned.

(a) Abstract of paper read before Edinburgh Medico-Chirurgical Society.

## MODERN METHODS OF VACCINATION AND THEIR SCIENTIFIC BASIS. (a)

By **MONCKTON COPEMAN, M.D., F.R.C.P.**,  
Lecturer on Public Health, Westminster Hospital, &c.

AFTER briefly recapitulating the history of the introduction of vaccination and the various Acts of Parliament regulating its application, Dr. Copeman mentioned that his attention had early been directed to the prevention of erysipelas as an accidental complication of vaccination by an unfortunate epidemic at Norwich, which suggested to him the desirability of substituting serum preparations of calf lymph for the prevailing arm-to-arm method. Alluding to the common belief that calf lymph produced worse arms than the method of arm-to-arm vaccination, he observed that, as a matter of fact, culture plates inoculated from calf lymph showed a greater number of colonies of micro-organisms than when inoculated from lymph taken from the human arm. This, he had no doubt, was due to the greater difficulty in cleansing the skin of the calf as compared with that of a child. The opacity which occurred in stored lymph was due to the increase in the number of bacteria in the tube. He had been able to obtain inhibition of the growth of these organisms by mixing the lymph with 50 per cent. of pure glycerine in water, and further, he had been able to show by a series of plate cultivations that the number of bacteria steadily diminished, so that at the end of one month after the admixture no organisms were present on the culture medium. Not only did this method kill off all the usual contamination bacteria but it would also destroy those of tubercle and erysipelas, when these were added experimentally, in comparatively large quantities. Dr. Copeman then dealt with the preparation of the lymph under the following heads. 1. *Vaccination of the calf.*—Suitable animals had to be selected, from three to six months old; they were placed in the quarantine stable for a week, their general health was ascertained, and they were weighed and their temperatures were noted. The lower part of the abdomen was shaved, and after cleansing was inoculated with glycerinated calf lymph by numerous parallel linear incisions. 2. *Collection of the vaccine material.*—This was taken 120 hours after inoculation. The vesicles and their contents were collected with a sterilised Volkmann's spoon, and in this way the vesicular pulp was removed without admixture with blood. The animal was then slaughtered and was examined by a veterinary surgeon and the lymph was not used until the animal in question had been certified to have been healthy. 3. *Glycerination of the vaccine material.*—The lymph pulp was triturated and mixed with six times its weight of a sterilised mixture of 50 per cent. pure glycerine in distilled water. 4. *Storage of emulsion.*—The emulsion was then placed in small test-tubes and put into an ice-chest, and week by week agar-agar plates were established from the emulsion with the result that the number of colonies was shown to diminish successively. At the end of a month the plate rarely showed any colonies. 5. *Use of the lymph at the animal vaccine establishment prior to distribution.*—Samples of the lymph were taken and children were vaccinated. The results of these vaccinations were recorded, and from the number and size of the vesicles an estimate was made as to the potency of the lymph. 6. *Transference of the glycerinated lymph to capillary tubes for distribution.*

(a) Abstract of paper read before the Royal Medical and Chirurgical Society, December 10th, 1901.

—The lymph was transferred to capillary tubes and sealed and stored in ice-chests ready for distribution. 7. *Recording the results of vaccination by public vaccinators.*—Each public vaccinator had to record the number of the tube used, the number of persons vaccinated, the number of scarifications made, and the number of vesicles obtained. The success attending the use of this lymph in the first year showed a case success of 93 per cent. and an insertion success of 83 per cent., and at the present time it was no unusual experience for returns to show complete case and in ertion successes. Dr. Copeman then dealt with the regulation as to the mode of vaccination, with the question as to what constituted efficient vaccination, and with the after-treatment of the arm. He said that he had removed the glycerine from the lymph in order that the lymph might dry more rapidly on the arm, but he did not think that the results were worth the trouble involved in the preparation of such lymph. There were fifty-nine deaths in which vaccination was mentioned as a cause, or one of the causes, in the certificate, in the year 1893, rather more than one a week, whilst in the year 1899 in only 25 deaths was vaccination incriminated. He then dealt with the relation of vaccinia to small-pox and stated his belief that the former was an attenuated form of the latter, and in support of this statement he quoted the following experiments. He said that it was well known that a calf could seldom be inoculated directly from a case of even confluent small-pox in the human subject, but that if in the first place a monkey were inoculated with lymph from such a case good vesicles developed. If lymph was taken from these vesicles and a calf was inoculated poor vesicles were produced; if a second calf was then inoculated from the first a good crop of vesicles was produced; and then if a child was inoculated with lymph from this calf a typical vaccinia was produced. A second series of experiments in which the lymph from a case of confluent small-pox was passed through two monkeys in succession and then through two calves before the child was vaccinated gave similar results to the experiments above described. Such evidence seemed strongly to support the view that vaccinia was an attenuated form of small-pox. He thought the evidence went to show that though ordinary, even severe, small-pox was with difficulty inoculated in the calf, the inoculated variety of small-pox, i.e., that which was produced when the inoculation of small-pox virus was the recognised means of obtaining immunity, might be transmitted to animals and thus produce the disease in the calf from which vaccine was derived.

### Clinical Records.

#### TWO CASES OF CONGENITAL ELEVATION OF THE SCAPULA. (a)

By **MR. ROBERT JONES, F.R.C.S., ED.**,

Honorary Surgeon, Royal Southern Hospital, Liverpool, &c.

The condition was first described by Sprengel in 1890, and is known as "Sprengel's deformity." It consists of an elevation of the scapula above the level of its fellow, accompanied by rotation, approximating the lower angle to the middle line, with limitation of scapular and humeral motion and sometimes with a slight curvature of the spine. The etiology of the affection is doubtful, but the probability is in favour of constricted foetal position.

CASE I.—A boy, set. 5. The deformity was noticed when he was vaccinated at three months old. The

(a) Notes of cases now before the Liverpool Medical Institution.



child is weird-looking, walks with a stoop, and carries his head slightly bent to the left side. The left shoulder is raised two inches above the right. The distance of the inferior angle of the scapula to the spinous process of the vertebra is  $1\frac{1}{2}$  ins., on the right side  $2\frac{1}{2}$  ins. The left superior angle  $\frac{1}{2}$  of an inch from the spine, the right 2 ins. The scapula is therefore rotated. The length of the posterior border of the left scapula 4 ins., right 5. From left acromion to episternal notch  $3\frac{1}{2}$ , right 4 ins. The arms are of equal length. The dorsal spine is slightly curved, the convexity pointing backwards. There is a marked limitation in the movement of the scapula. Rotation of the arm is normal. Abduction and adduction are limited. The trapezius muscle is contracted and tight. No exostoses can be felt, and no articulation with rib or spinous process.

CASE II.—A girl, *et. 7*. The left scapula is displaced upwards, its lower angle touches the fifth rib, whereas the right touches the seventh rib. The movements of the shoulder are limited, so that the arm only comes up to a right angle without movement of the scapula; she cannot place the hand at the back of the neck. The right scapula, as shown by the radiograph, is normal in site and structure. The left, or displaced bone, has the axillary border shorter and more curved than that on the opposite side. The posterior border consists of an upper portion with which the extraneous portion of bone articulates, and a lower portion which is nearly straight. At the junction of these two portions there is a distinct projecting angle. The abnormal portion of bone is triangular, its outer border articulating with the upper portion of the posterior border of the scapula, and its inner angle with a spinous process of the cervical vertebra. The extraneous portion of bone was removed in order to increase the range of scapular movement, and proved successful. Examined three years later, the patient has much improved, and stands with shoulders square. There is a projection of the upper and inner angle of the scapula, and this still blocks somewhat the movement of placing the hand behind the back of the neck. The deformity was noticed a month after birth.

#### A CASE OF CONGENITAL DISLOCATION OF THE SHOULDER.

Cases of this kind may be grouped into those due to faulty development and those due to injury during birth.

The patient, *et. 9*, showed the head of the humerus displaced backwards under the acromion and rotated inwards, so that the rounded portion was felt posteriorly. On pressing in front the inner margin of the glenoid cavity is felt. The condyles of the humerus point antero-posteriorly as the arm falls to the side. Measurements:—Length of post. border of left scapula, 5 ins.; ditto of right,  $4\frac{1}{2}$  ins. From angle of scapula to left acromion, 6 ins.; ditto of right,  $5\frac{1}{2}$  ins. Post border of left scapula,  $5\frac{1}{2}$  ins.; ditto right,  $4\frac{1}{2}$  ins. The arm measurement from apex of right acromion to ext. condyle,  $7\frac{1}{2}$  ins.; ditto from left acromion, 9 ins.

There is an elevation of scapula, and on fixing it, the humerus can be slightly abducted but not adducted. The range of scapular movement is increased, so that in spite of humeral fixation the boy can place his hand behind his head and behind his back. Radiograph shows the glenoid thickened, not due to exostosis but to the new socket formed on its posterior aspect. The head of the humerus smaller than its fellow, the shaft attenuated. Mr. Jones classes the case among the co-natal traumatic displacements, and as to treatment, trusts to stretching exercises.

MR. G. MELLIN has offered to place at the disposal of the Prince of Wales's Hospital Fund for London a quantity of "Mellin's Food" equivalent in value to £10,000, to be distributed among London hospitals at the rate of £2,500 worth per annum. The offer has been gladly accepted.

## Transactions of Societies.

CLINICAL SOCIETY OF LONDON.  
MEETING HELD FRIDAY, DEC. 13TH, 1901.

MR. HOWARD MARSH, F.R.C.S., President, in the Chair.

DR. S. H. HABERSHON ON

THE ASSOCIATION OF MOVABLE KIDNEY ON THE RIGHT SIDE WITH SYMPTOMS OF HEPATIC DISTURBANCE.

In introducing the subject of his paper Dr. Habershon defined the term hepatic diathesis, and instanced three classes of patients in whom functional hepatic symptoms were liable to be set up, viz, those of definite biliary susceptibility, the cases in whom biliousness was induced by circumstances well within their control, and a third class in whom the hepatic symptoms depended on a ptosis of kidney or liver. The object of the paper was to emphasise the medical aspect of the condition known as movable kidney, and to describe certain groups of biliary symptoms which were prominent. The cases of movable kidney occurred chiefly in women, and statistics were given from the writings of Glénard, Landau, Mathieu, and others to show that from 20 to 28 per cent. of all dyspeptic women possessed a movable kidney. The causes, diagnosis, and symptoms were then narrated, and among the difficulties that occurred in the recognition of the condition, the variability of position, the simulation of an enlarged gall bladder, of Riedel's lobe (of the floating lobe) of the liver, and of certain renal and appendicular conditions were cited. The mortality occurred in an enormous proportion of the cases on the right side. The symptoms of movable kidney were *subjective* and *visceral*. Among the latter class the left kidney was more prone to produce gastric than hepatic symptoms. Hepatic conditions occurred in cases of movable kidney of the right side. They were defined in three groups:—(a) *general symptoms of severe biliousness*, (b) *attacks of colic* simulating true biliary colic from the passage of gall stones, and probably identical with Diett's crises, (c) *attacks of jaundice*, three cases reported by MacGlagan being quoted. The cause of these hepatic disturbances was next discussed, and of the three possible causes, due to pressure on the duodenum or common bile duct, traction on the middle portion of the duodenum, and reflex irritation of the pneumogastric nerve, stress was laid on the latter two. The author divided cases of hepatic symptoms into three classes from the point of view of their symptomatology. 1. Cases of uncomplicated ptosis of right kidney. 2. Cases in which the renal condition was accompanied by a coincident ptosis of liver. 3. Cases in which the renal ptosis was part of a general enteroptosis. In the slighter degrees of ptosis of right kidney the hepatic symptoms were often paramount, and the following classes of symptoms should lead to the suspicion of movable kidney. First the *intractability* of the hepatic condition which did not yield to ordinary methods of treatment. Secondly, the fact that the symptoms were produced or aggravated by *shaking* or exertion in any form, this being entirely contrary to the experience with regard to an ordinary biliousness, not due to ptosis of kidney. Eight cases were reported to illustrate the various forms of hepatic symptoms, and the relief afforded by replacing the kidney in position.

MR. LUCAS said he did not perceive anything peculiar in the symptoms to which the author had called attention. He had remarked them in quite a number of cases and he referred to one case in particular, that of a trained athlete, who suffered from very severe symptoms which absolutely incapacitated him for work. They were attributed to gall-stones, but he was seen by Sir Spencer Wells, who discovered a floating kidney for which a belt was ordered, which only exaggerated his sufferings. This patient was thoroughly and permanently relieved by fixation of the organ. He suggested that the occurrence of hepatic symptoms in this association was amply accounted for by the relationship of the

right kidney to the second part of the duodenum into which the bile duct opened. He himself had long since remarked that the pain of right movable kidney was very apt to assume a hepatic character.

Dr. MACLAGAN referred to a case he had seen many years ago in consultation with the late Matthews Duncan, who had discovered the tumour, but frankly said he did not know what it was, adding that it did not seem to harm the patient much, and had best be left alone. In other cases, however, the condition gave rise to great inconvenience and discomfort, and these were almost invariably cases of right movable kidney, the left rarely giving rise to trouble. He had seen two left floating kidneys, both in males. He had never seen any good result from the use of a belt and pad, but there was a truss invented by Treves which, if properly applied, was very effectual. In emaciated women the rest cure was often very beneficial probably because it favoured the redeposition of fat around the kidneys and elsewhere. These cases might be divided into three classes, (1) those in which the displacement gave rise to no great trouble, (2) those in which it caused much distress and discomfort, and (3) those which required to be dealt with surgically. He mentioned three cases which had been diagnosed as due to gall-stones in which fixation of the kidney was followed by permanent cure.

Dr. T. STACEY WILSON dissented from the view that a belt did no good in these cases. He himself had been in the habit of using the same form of belt for all patients, and with good results.

Dr. T. STACEY WILSON read a paper in which he laid down the following propositions:—In Mitral Incompetence: I.—The process of compensation necessitates dilatation of the cavity of the left ventricle, as well as hypertrophy of its walls, and the amount of dilatation in the compensated heart is directly proportional to the amount of blood which regurgitates into the auricle at each beat of the heart. As mitral incompetence involves the leakage back into the auricle of a certain part of the contents of the ventricle at each beat of the heart, it therefore follows that in order to compensate for this leakage and allow of a normal amount being thrown into the aorta at each beat, 1. Firstly: the ventricle must enlarge so as to hold both the normal amount and that which will escape back into the auricle. 2. Secondly: It must thicken its walls so as to be able to move this additional volume of blood. 3. The theory of the enlargement of the ventricular cavity is as follows:—On the first occurrence of regurgitation through the mitral valve a progressive over-distension of the auricle will theoretically result from the leakage of blood back into that chamber. As soon, however, as the size of the auricle exceeds that of the ventricle, the latter will during its expansion be drawing towards itself more blood than it can hold; and the momentum of the blood which cannot find entrance will tend to dilate the cavity of the ventricle. In this way the ventricle will be dilated by its own aspiratory force until its size is comparable to that of the auricle. This will not occur until the ventricle is large enough to hold the full amount of the leakage in addition to its normal contents. (*Vide* writer's paper "Clin. Soc. Trans.," vol. xxxiv., Case 3.) II.—The dilatation and hypertrophy, which can compensate for the defective working of the left ventricle during systole, will, according to this theory, also relieve the auricle from embarrassment during diastole by ensuring the proper filling of the ventricle. For (1) Since the enlarged ventricle is able to accommodate all the regurgitated blood in addition to its normal contents, it follows that it will be as easy for the abnormal amount of blood to enter the abnormally large ventricle as for the normal amount to enter the normal ventricle. And (2) The increased muscularity of the enlarged ventricle will ensure the slight addition to the aspiratory force which is required to draw the larger amount into the ventricle. III.—Therefore by the time the expansion of the ventricle has ceased, the auricle will have been relieved of all the regurgitated blood, and only the normal amount will remain to be dealt with by it.

IV.—Therefore in fully-compensated mitral regurgitation no extra work will be thrown upon the left auricle, and there will be no embarrassment of the pulmonary circulation and no accentuation of the pulmonary second sound. V.—Neither would there be any dilatation of the left auricle unless the regurgitation were extreme. Since the systole of the auricle and of the ventricle together occupy one-half of the cardiac cycle, it follows that only one-half of the full volume of blood will normally enter the auricle during this portion of the cycle. Therefore there will be room in the auricle during the ventricular systole for any amount of regurgitated blood up to one half of the total quantity put into circulation at each beat. If, on the other hand, the amount of regurgitation were to exceed one half of the normal output of the ventricle there might be dilatation of the auricle, even when compensation was fully established. VI.—According to this theory of compensation there ought to be a slight increase in the loudness of the aortic part of the second sound, because the greater expansive force of the hypertrophied and dilated ventricle will induce a more powerful recoil of the blood in the aorta, and will result in a more powerful closing and stretching of the aortic valves than in the case of the normally-acting ventricle. In mitral stenosis, according to this theory, the left ventricle increases its aspiratory power in order to facilitate the entry of blood through the narrowed orifice, and so establish compensation. This is brought about as follows:—VII.—In mitral stenosis the left ventricle contracts with greater force than normal in order that the rebound, both muscular and elastic, may be correspondingly increased. 1. An evidence of this is the increased loudness of the first sound which occurs in mitral stenosis. 2. Temporary embarrassment of the circulation is accompanied by an increase, often excessive, in the loudness of the first sound, which lessens again as the circulation improves. 3. This increase in the force of the ventricular contraction is also suggested by the occurrence of the hypertrophy of the left ventricle, which is not infrequently noticed in mitral stenosis. VIII.—The left ventricle alters its beat. Its contraction terminates with greater suddenness and force than normal. This concentration of ventricular effort at the termination of the systole has the effect of further increasing the force of the ventricular recoil which immediately follows the systole, lasting as it does only one-tenth of a second. 1. This is the explanation of the sharp and loud end of the first sound which is so characteristic of mitral stenosis. 2. The characteristic cardiograms of mitral stenosis often show a more sudden recession of the heart from the chest wall at the end of the systole than in the normally-beating heart. IX.—As a result of this additional aspiration the auricle can be relieved of much, if not all of the additional work which the narrowness of the mitral valve entails. We find very frequently an absence of dilatation of the left auricle in mitral stenosis where compensation was perfect at the time of death. X.—Therefore, in compensated mitral stenosis, if the narrowing be not very excessive, no extra work is thrown upon the right side of the heart, and there is no engorgement of the lungs. 1. As evidence of this, we find the pulmonary second sound of normal loudness, even in cases of severe mitral stenosis. 2. We find that the accentuation of the pulmonary second sound which is characteristic of failing compensation, gradually lessens as compensation improves. 3. We may find no clinical evidences of pulmonary congestion or engorgement even in severe cases of mitral stenosis. XI.—We may also expect some increase in the loudness of the aortic second sound, apart from that due to increased arterial pressure, because of the increased ventricular aspiration, as suggested in Proposition VI.

After some remarks by Dr. Ross, who challenged the suggestion that the suction of the auricles conferred any momentum on the incoming blood, Dr. KINGSTON FOWLER observed that the author's views were contrary to those which he himself taught. He maintained that whereas in the normal heart while the blood flowed from the auricle into the ventricle, the curtains of the mitral valve were gradually floated up and came into

apposition before the acme of the dilatation took place, the first sound resulting from the edge of the closed curtain. In mitral stenosis this closure could not take place, and the accentuation of the first sound was then produced by the shock bringing together these thickened curtains.

ROYAL ACADEMY OF MEDICINE IN IRELAND.  
SECTION OF SURGERY.

MEETING HELD, ROYAL COLLEGE OF SURGEONS, ON  
DEC. 6TH, 1901.

The President, MR. THOMAS MYLES, in the chair.

THE following living exhibits were shown:—

MR. D. KENNEDY: (a) Case of enlarged liver after trauma; (b) Two cases showing results of osteotomy for bow leg.

MR. B. L. SWAN: Case of bilateral radical cure of inguinal hernia, with interval of four years between operations.

MR. HENRY CROLY: Patient operated on for double empyema.

The following card specimens were also shown:—

MR. H. GRAY CROLY: (a) Stomach lacerated by shaft of dray—cycle accident; (b) limb removed by amputation at hip-joint for sarcoma.

MR. D. KENNEDY: (a) Thymus and thyroid glands of child who died under chloroform; (b) four skiagrams showing foreign body in œsophagus, stone in bladder, congenital absence of radius, and fracture of olecranon.

MR. B. L. SWAN: (a) Two kidneys and part of hypertrophied ureter removed by ventral incision from patients, æt. 23 and 35; (b) comminuted extracapsular fracture from man, æt. 90, who died three days after injury.

MR. HENRY CROLY: (a) Tumour removed from infra-scapsular region; (b) stricture of pylorus; (c) cystic hygroma.

MR. J. S. McARDLE read a paper

ON INTRACRANIAL HÆMORRHAGE,

which we hope to publish in full in our next. Introducing the subject, the author said that the present paper had its origin in his desire to show how futile the treatment of intracranial hæmorrhage is by applying ice to the head and depressing the feet. It is not so very long ago that he heard such treatment advocated in that room. Brain surgery seemed to have been neglected for abdominal surgery, a fact which may in part account for the want of progress made in the former. It is, however, necessary that a great change should come over our theories and procedure in brain surgery—he had seen patients die from intracranial pressure who should have lived. Tumours of the brain due to microbic tension will afterwards receive more thought, for such drugs and applications to relieve intracranial tension are at their best only palliatives. He had no belief in the well-known general practice of ice to the head and the internal administration of mercury. Intracranial over-tension should be treated as you treat over-tension elsewhere, and as illustrative of the value of relieving the tension by operative means. He quoted the following cases:—

CASE I.—William Green, æt. 40, came under observation in 1890. On November 18th of that year he fell into the hold of a vessel; he cut the forehead over the right eye, and went to Sir P. Dun's Hospital, where it was dressed, and afterwards he went home apparently all right. On the following Monday, three days afterwards, his stomach was sick, and he suffered from a pain in the head. Tuesday his left leg became powerless, Wednesday he came under care in St. Vincent's Hospital. The house surgeon reported his temperature as sub-normal, his pulse was slow, but he answered questions quickly and intelligently. The next day the house surgeon reported that the patient had had convulsions, his thumb was flexed on his palm, his hand on his forearm, his forearm on his arm, and his arms were raised. That evening the skull over the point of injury was trepanned

and a clot the size of a sixpence was come on, which was surrounded by a greenish effusion. Immediately after the operation the patient showed signs of improvement, and in fourteen days was going about.

CASE II.—A boy, æt. 16, got a kick of a horse on the forehead, and he became unconscious. Whilst in this state the boy's wound was dressed; after a little his consciousness was restored to be again lost; then he came to St. Vincent's Hospital. On admission his breathing was laboured, his pulse slow, and the site of the wound greatly swollen. The skull was trepanned over the site of the middle meningeal artery, which was found to have been penetrated by a fine spicula of bone, removed the effused blood and some portions of the frontal bone, together with the crista galli of the ethmoid. The effect of the injury on the boy's temper was peculiar. Prior to the injury he was of a good temper, afterwards he became a devil, and has gradually become his old self.

CASE III.—A boy fell, striking his head on a metal step. He got up, walked home, and came into dinner; whilst at the table he got drowsy, vomited, and in a few days got epileptic fits. The parents of the boy thought his case hopeless. It was noticed that just before a convulsion the eyes deflected. Trepanned over the fissure of Rolando, giving exit to two grammes of fluid. The boy made an uninterrupted recovery.

CASE IV.—A boy playing on a pile of boxes fell. The case was an aggravated one, and the parents were hopeless. The father said, "Do what you like with him; anything is better than his present state." The boy complained of a curious series of phenomena of the visual sense. He had a single ring of fire, then a flash, then he knew no more. Trepanned over the fissure of Rolando, and found nothing until the auriform lobe was probed, when exit was given to a small quantity of fluid.

CASE V.—A boy riding down the Phoenix Park on a bicycle, fell, coming down on his cycle. His wound was dressed at Steeven's Hospital, and he felt so well that he walked home. He gradually, however, lost the power of his right limbs, and when he came under notice was trepanned over the posterior branch of the middle meningeal artery. An extra-dural hæmorrhage was come down on, which spread backwards and downwards, making its way into the middle cranial fossa, from which it was scraped out. The case progressed to convalescence without one unfavourable symptom.

CASE VI.—A man riding a race fell, and the horse coming after hit him with the lock of his shoe. He never lost consciousness and was driven home, a distance of seven miles, on a car. He was trepanned, and a blood-clot about an ounce in weight was removed. He was practically well, when, on the thirteenth day after the operation, he became thirsty and got dissatisfied with short drinks of water. At 7 a.m. he got a tumbler of water, which he drank off, and soon afterwards died. The cause of death was septic infection, the source of which could not be found out. Some months afterwards the mystery was solved by the confession of a friend of the patient that on the day of the accident he had probed the wound with his finger—a curiosity that cost a valuable life.

MR. MYLES thought it might safely be said that no surgeon hesitates, when necessary, to raise or remove portions of the cranial bones. Where they were now assembled excellent papers on cranial surgery for cerebral effusive pressure effects, and operation on the sinuses had been read, indeed the "Transactions" of the Academy are rich in such. It is open to question if the symptoms in a case are wholly due to intracranial tension or injury to cerebral tissue. Withal it seems that death is usually due to intracranial tension rather than cerebral injury. To trepan the skull, examine the ventricles, and tap them seems easy, but the case is not so simple when the injury results from some underlying condition of the kidney, as Bright's disease, atheroma of the arteries, or syphilis. Some cases recover after many hours, or even days, without any operative interference, nevertheless they must acknowledge that all the drugs of the Pharmacopœia will not relieve intracranial tension. He had a case of a man who fell from

a two-storey window; he was, when seen, quite unconscious, and there was no indication other than the unconsciousness of the accident. It occurred to him that an X-ray photograph would assist them, and it did, for it revealed a whole series of cranial fractures. He trepanned in three places, removed a large clot, and the patient became conscious. In a case of Jacksonian epilepsy he operated, and the patient remained well for a time, but has had one fit since.

Mr. SWAN remarked that Mr. McArdle's paper had opened for them a new line of thought as to the conditions that produce cerebral tensions. From the title of the paper he thought it would have dealt with other than traumatic cases. Most persons would have acted as Mr. McArdle did in similar cases. The great difficulty in cases of intracranial tension is to locate the injury; when there is a depressed fracture the difficulty of diagnosis does not exist. A girl, who fell off a merry-go-round, came under his care with a depressed fracture of the skull. Her head was contracted; she had epileptic convulsions. He trepanned, raised the depressed portion of bone, and the girl got well, and remained so for six months; then the fits recurred. Shock appears to have the power of interrupting the sequence of the Jacksonian epileptic fits.

Dr. POLLOCK said that severe cases might recover without any operative interference was known to all of them, but the following case so well illustrated this that he thought it worth recording. An Australian gentleman, when riding over his farm, met with an accident. His horse fell, throwing him, and there he lay for two hours unconscious; when he came to he found the horse lying on top of him; he used his spurs on the animal, which caused it to rise. Then he succeeded in getting on his feet, mounted the horse, and rode home, a journey of nine miles. When he reached home he became again unconscious, and remained unconscious for three weeks. There was no medical advice obtainable in the district, and advice was procured by telegraph from Sydney two hundred miles away. After consciousness returned he had from five to ten epileptic fits daily. He went by rail to Sydney, from Sydney to London, on the journey home he never had a fit. After some time at home, finding he was free from fits, he rejoined his militia regiment, and being an excellent judge of horses he was offered a good appointment by the Government in South Africa, where he now is, and has remained free from the fits since he left Sydney.

Mr. H. GRAY CROLY said that when he filled the presidential chair of the College, he read a paper on injuries of the head, and advocated then and now prompt surgical intervention. Some years ago he was called to see a man who fell on some spiked railings, getting a punctured fracture of the skull. On his arrival he found the patient aphasic and in the hands of physicians, who, five of them, were dosing the poor man with bromides and iodides, and refused to sanction trepanning. The gentleman left the country and went to the United States to be trepanned, and from there went to Paris, where the piece of broken bone came away before the surgeons could operate, and now he is quite well. In the case of a boy who was kicked by a mule, he raised the fractured portions of the cranial bones, and came on a large blood-clot lying on the dura mater. When it was removed the boy regained consciousness, and in a short time was quite well. The difficulty in all these cases is to find the locus of tension. He had seen alarming hæmorrhage from the ear, without any sign of external injury. A man was brought to him with the history of having fallen on the back of his head; he answered in monosyllables and gradually became unconscious. Prior to death he had 250 convulsions. The autopsy revealed a broken occipital, with a blood-clot that covered the cerebellum. Where were you, in such a case, to apply the trephine?

Mr. TOBIN had the advantage of seeing almost all Mr. McArdle's cases, but one must not expect the same progress in cranial and cerebral surgery as in abdominal. In the latter, one can see and handle all the viscera, but the skull opening is so small that but a limited view could be obtained of

the cavity and its contents. All surgeons trepan in cases of compound fracture. But he considered that a fracture associated with soft tissues necrosed from pressure is quite as dangerous as the compound, and necessitates equal care in dressing. Another point he would call attention to by an illustrative case:—A sergeant put a revolver to his head and produced a compound fracture, the wound never properly healed, the patient got epileptic fits, and a small projecting spicula of bone was then removed. All this time there appeared no evidence of tension. The patient was placed on his side with the trepanned bone on the pillow, and during the following night there was a profuse flow of serum, after which the man made an uninterrupted recovery. There seems a dread of putting a patient on the trepanned side, which he considers is the most suitable one to allow of free exit for any fluid present.

Dr. COX remarked that he was a believer in surgery, and advocated it in such cases as those referred to. He once trepanned a patient in a provincial infirmary, and removed a portion of a reaping hook from the brain of a Western peasant. He also recommended trepanning of the mastoid in a case in which he was consulted; his advice was not followed. Afterwards the patient was twice trepanned, but not at the locus of the pus; finally he died. He holds that cases of kidney disease or disease of vessels are not amenable to surgical interference.

Mr. LENTAIGNE said Mr. McArdle's paper alluded to the treatment of intracranial hæmorrhage some time after it had occurred. It may so happen that the surgeon is called in when bleeding is actually taking place from a small opening in the vessel. Mr. Victor Horsley in such cases recommends ligation of the carotid. A case of his was of this nature: The patient, a lady, had convulsions of the right leg and right arm. He made pressure on the left carotid, the convulsions ceased in the leg and arm, and the patient was able to move the leg up and down. The pressure was now discontinued, and soon afterwards she got difficulty of speech and paralysis of the limbs of the right side. By the aid of assistants pressure was now kept up for some time, and the patient recovered to a great extent the use of speech and the power of her limbs.

Dr. MORE O'FARRELL would like to ask Mr. McArdle on the use of trepanning in intracranial tension in tuberculous meningitis, where day by day the tension increases. If in such cases we could operate there might for such cases be a chance of life. Even to open the abdomen in peritoneal tuberculosis benefits, might it not be equally useful in tuberculous meningitis.

Mr. McARDLE, in reply, said that on a future occasion he proposed treating of operative measures in intracranial tension of non-traumatic origin.

The Section then adjourned.

#### EDINBURGH MEDICO-CHIRURGICAL SOCIETY. MEETING HELD DECEMBER 4TH, 1901.

Dr. T. R. FRASER, President, in the Chair.

Dr. WILLIAM ELDER and Mr. MILES showed a patient after removal of a tumour from the left prefrontal lobe of the brain. The patient was a man, æt. 47, admitted to hospital in September with the history of having suffered from pain in the back of the head since May. His symptoms otherwise were chiefly mental—he had become melancholic and emotional, and had been quite unfit for work for about a month before admission. There was a syphilitic history, and a scar resulting from an old gumma in the right frontal region. On admission the patient was dull and apathetic; he had lost all self-control, and exposed himself indecently. His reflexes were normal, but he had lost command of his bowels and bladder. The optic discs were blurred, and there was a soft swelling over the left frontal bone. Shortly after admission he became comatose, and was obviously going down hill. A diagnosis of left prefrontal tumour was made, and on trephining a very hard gumma was found in the brain at that situation. This was shelled out, and the patient recovered. The benefit of the

operation was immediate. Next day the patient was entirely sensible, and, from being dull and melancholic, he passed to the opposite extreme, becoming rather forward, and inclined to be familiar. This, however, passed off, and he gradually regained his normal mental state.

DRS. GULLAND and LOGAN TURNER showed a girl after operative treatment for laryngeal tuberculosis. The patient had phthisis of both apices, and a localised tuberculous deposit completely obscuring the left true cord. This was removed by intra-laryngeal forceps at several sittings, and the girl had benefited greatly. The laryngeal mischief was apparently healed, while the pulmonary tubercle was undergoing arrest.

MR. SHAW McLAREN showed a patient after recovery from compound depressed fracture of the skull and leptomeningitis.

The following card specimens were shown:—By Dr. Elder and Mr. Miles, tumour removed from prefrontal lobe of brain; by Dr. F. D. Boyd, bowel from a case of acute dysentery; by Dr. Burn Murdoch, large gall-stones which produced practically no symptoms; by Mr. Alexis Thomson, large gall-stone which caused acute intestinal obstruction, and was removed by enterotomy; by Dr. Harvey Littlejohn, (1) surgical instruments used by natives of Northern Nigeria; (2) kidney and ureter showing effect of accidental ligation of ureter for removal of intra-ligamentous ovarian cyst; (3) injuries received in a fall from a window; by Mr. C. W. Cathcart, (1) Toy whistle removed from the trachea of a boy, *set. 9*, after being six weeks in the air passages; (2) portions of needle and thread, also Röntgen ray photograph of same, removed from the knee of a girl, *set. 7*; by Mr. Caird, carcinoma of ascending colon from a case of primary resection and suture, and lung preparations of Buchhold's method.

DR. CHALMERS WATSON showed photographs of poultry, showing some results of an experimental research on the comparative pathology of gout.

MR. DAVID WALLACE demonstrated Beckmann's apparatus for ascertaining the freezing point of blood.

DR. DAWSON TURNER showed an apparatus he had devised for estimating the electrical resistance of blood. It consisted of two electrodes, one cup-shaped, the other conical and fitting the cup. These were covered with spongy platinum, and could be adjusted to one another by a micrometer screw. Five mg. of blood were taken up in a graduated pipette and blown into the cup electrode. The second electrode was then screwed down upon it so that a layer of blood of known thickness was interposed between the two. The resistance to alternating currents was measured by a Wheatstone bridge and a telephone. From about 500 observations he found that the average resistance of normal blood was from 500 to 600 ohms. He was now making observations on the blood in various diseases, the most striking result obtained so far being that in pernicious *anæmia* the resistance was reduced to about 250 ohms.

DR. TURNER also showed skiagrams of a case of syphilis in which the bones were absolutely transparent to the X-rays.

DR. LAWSON read a paper on "Some Clinical Observations of the Temperature of Phthisis treated by Open-air Methods," which will be found on page 652.

The paper was discussed by Dr. JAMES, who pointed out that inverse temperatures could sometimes be explained by a reference to the previous habits of the patient; he had seen it in night nurses, night policemen, and so on; by Dr. GULLAND, and by Dr. TAYLOR, who expressed his preference for the method of taking temperatures in the axilla rather than in the mouth or rectum.

DR. DAVID WALLACE read a paper on "Supra-pubic Prostactomy," which will be found on page 653.

The paper was discussed by Mr. CAIRD, who endorsed Mr. Wallace's opinion as to the superiority of supra-pubic cystotomy, by Mr. CATHCART, by Mr. MILLAR, who deprecated too early initiation of catheter life, by Mr. CORTELLI, who favoured the perineal method in many cases, and by Mr. SCOT SKIEVING.

## LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD DEC. 7TH, 1901.

The President, MR. EDGAR A. BROWNE, in the Chair.

CASES were shown by MR. ROBERT JONES (for which see "Clinical Records.")

DR. W. B. WARRINGTON brought forward two cases. (1) Acute pneumonia characterised by long duration and intermittent type of pyrexia, the crisis not occurring till the nineteenth day. This condition suggested that the case might be an acute phthisis beginning with acute pneumonia. Symptoms were profuse sweating, progressive emaciation and hæmorrhage. The subsequent course of the disease showed that he had to deal with a migrating pneumonia, possibly of influenzal origin. (2) Acquired hydrocephalus in a man, *set. 35*. The patient for eight months showed signs of cerebral tumour, *viz.*, marked optic neuritis, with headache and some vomiting, tremors in the tongue, slight exophthalmos of one eye, and weakness in the legs. His mental faculties became markedly impaired, and he gradually passed into a comatose condition. At the autopsy dilatation of the lateral ventricles was the only gross lesion found, the microscope showed inflammatory thickening of the ependyma of the fourth ventricle. The nature and diagnosis of each case were briefly discussed.

DR. T. R. GLYNN briefly remarked upon the second case, and related a case similar to this in which there was marked optic neuritis, headache, reeling gait, staggers, &c., and a diagnosis of cerebellar tumour made. The patient was trephined over the cerebellum, no tumour was found, but some cerebro-spinal fluid escaped after opening the ventricle, and the patient recovered. Such cases explain those cases of apparent cerebral tumour that recover.

MR. DAME HARRISON related a similar case of relief of symptoms after opening the lateral ventricle.

MR. RUSHTON PARKER read a note on "a series of fourteen foreign bodies, various in nature and locality," and remarked that some foreign bodies are mere curiosities more or less amusing, others, while extraordinary, are curious from the little harm they do, while others, commonplace in themselves, may be the cause of danger and even tragedy. An individual foreign body may be very interesting itself, and in its circumstances alone, but he thought that collective reference to a selected set might by comparison and contrast give an interest to each intruder quite as great as that afforded by considering it alone. The cases were, with one exception, from his own practice. 1. Wooden splinter, over 2½ ins. long and from ¼ to ½ in. wide and thick, embedded in the pterygo-maxillary region of a man, where it was broken off a bundle of swinging boards that struck him in the right lower eyelid. The object was thought to be loose bone, and was withdrawn after a few weeks, early in 1878. 2. Piece of a sailor's knife blade, 2½ ins. long and ¼ wide, broken off in the left pterygo-maxillary region of a man stabbed in New York. The object was removed fourteen days later at the Liverpool Northern Hospital by Mr. Puzey in 1879. 3. Gun breech and screw bolt, forced by the bursting of a fowling-piece into the middle of the owner's face and lodging five years in the nose. Removed through an incision under the upper lip, December 20, 1883. The objects weighed 3½ ozs., measuring 3 by 1½ by 1 in. 4. Piece of parasol rib, 3 ins. long, broken off in a woman's forearm. Removed after twelve days. 5 and 6. Cases in which a bullet was displayed by radiography and removed from subcutaneous regions of the leg and hand respectively in boys. 7. Radiographs of small bullet flattened against the lower end of the radius in a young man, and when seen two days after the accident the wound was healed and the bullet was left alone; and seen five years later had caused no inconvenience, and was radiographed again. 8. Radiograph of leaden pellet from an air-gun, between the metacarpal bones; removed a fortnight later, as it caused annoyance and apparently pressed on a nerve. 9. Photo of a piece of red rubber catheter over 3 ins.

long, encrusted with phosphatic calculus, from the bladder of a man, *æt.* 71. Calculus crushed and evacuated, catheter removed by lithotrite. 10. Photo of silver tooth-plate 2 by 1½ ins., extracted from the pharynx of a man, *æt.* 36, after nine hours. 11. Photo of tooth-plate, vulcanite and metal, with attachment hooks, 2 by 1 by 1 ins., swallowed, and removed eight days later by œsophagotomy with success. 12. Iron staple 1 in. long 1 in. wide, swallowed by a boy, radiographed and shown lying in the pelvis three days later and passed per anum next day. 13. A piece of turned oak, 7 by ½ by ¾ in., known as a "knitting-sheath," removed from the rectum of a man, *æt.* 70, after a fortnight. No harm resulted. 14. Radiograph of the ankle of a girl, *æt.* 15, showing a piece of glass broken off a strip of window-glass 1 in. long more than ½ in. wide and less than ¼ in. thick. The object had been there five years, causing slight, but very persistent, disability of the ankle-joint. It was removed with an end to all trouble. A radiograph was shown of the parts after removal of the glass and its shadow.

Drs. and Messrs. Damer Harrison, Alexander, Hill, and Briggs related instances of other foreign bodies, and commented upon some of Mr. Parker's series.

#### HARVEIAN SOCIETY OF LONDON.

MEETING HELD THURSDAY, DEC. 5TH, 1901.

The President, Dr. D. B. LEES, in the Chair.

MR. MANSSELL MOULLIN read a paper upon  
SOME UNUSUAL CASES OF MOVABLE KIDNEY.

Instances were given in which a movable kidney had given rise to all the symptoms ordinarily present in chronic gastric ulcer, including hæmatemesis, and had closely imitated biliary colic and inflammation of the appendix. It was pointed out that the diagnosis could nearly always be made by confining the patient to bed for a few days, as in the recumbent position the kidney fell back into its proper place and ceased to press unduly upon surrounding structures. Mr. Mansell Moullin particularly called attention to the occurrence of these symptoms in cases in which only the upper end of the kidney, and not the whole organ was displaced. This form of movable kidney had been called *anteversion* by Potain, who was the first to describe it, and who associated it with the occurrence of biliary symptoms, but who mistook the effect for the cause. In such probability *anteversion* of the kidney, which can only be appreciated by examining the patient when stooping forwards in a semi-erect attitude, is much more common than is usually believed, and is not unfrequently the cause of symptoms which are often thought to be of subjective origin.

The President, Mr. F. Jaffrey, Dr. Macevoy, and Mr. Hubert Phillips took part in the discussion, and Mr. MANSSELL MOULLIN replied.

#### WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD DEC. 6TH (West London Hospital).

The President, Mr. ALFRED COOPER, in the Chair.

#### CLINICAL EVENING.

MR. KEETLEY and Dr. SAUNDERS showed a case of Paroxysmal Neuralgia of the Trigeminal Nerve, in which pain had been relieved by stretching and excision of a portion of the two lower divisions of this nerve.

MR. KEETLEY showed also a case of an Osteoplastic Resection for Malignant Disease of the Nasal Fossa.

DR. TAYLOR showed a case of Congenital Absence of Clavicles. In reply to remarks by Mr. McAdam Eccles, Mr. Lloyd, and Mr. Keetley, he pointed out that though the sternal epiphysis showed some attempt at development, there was no part of the sterno mastoid attached to it; that the patient showed some signs of congenital syphilis which might be a factor in the production of the deformity; and that although possibly the nether limbs are more frequently the subject of congenita

defects, arrests of development are more serious and more profound as a rule when they occur in the upper limbs.

DR. BALL showed for Dr. Abraham a case of Lupus Erythematosus of the Face associated with Lupus Vulgaris of the Palate.

DR. CHAMBERS showed for Dr. Abraham a case of Nevus Linearis (so-called), affecting the right of the trunk.

DR. SAUNDERS showed a case of Pigmentation of the Skin in a boy, *æt.* 13, probably Addison's disease. This affection had come on gradually in the last four months. The pigmentation was general, with accentuation over the region of the back of the neck, the axillæ, the groins and genitals, and over the prominent dorsal spines. It was least over the chest, and backs of the upper arms. The mucous membrane of the mouth was affected. The symptoms were debility, anæmia, and heart weakness, with occasional attacks of vomiting and diarrhœa. The boy had improved considerably in general health under treatment, after attention to the digestion, with cod-liver oil and iron, though the pigmentation had somewhat increased.

DR. GRUNBAUM drew attention to two methods based on physiological observation, which might assist in the diagnosis of early cases of Addison's disease. Langlois found that the ergographic tracings obtained from patients with diseased suprarenal glands were unique, in that the curve produced by joining the apices of the contractions fell very rapidly. This indicates a rapid diminution in power on the part of the muscle, this diminution being much more rapid in Addison's disease than in any wasting disease, such as advanced phthisis. Dr. Grunbaum had had the opportunity of confirming Langlois's observations. The other method is based upon the effects of the administration *per os* of suprarenal gland. The only cases in which Dr. Grunbaum had been able to measure any increase in blood pressure were patients suffering from Addison's disease, but whether this was diagnostic of the disease he was not at present prepared to say.

#### SHEFFIELD MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD DEC. 5TH, 1901.

The President, Dr. C. H. WILLEY, in the Chair.

MR. EDWARD SKINNER showed specimens from a case of Melanotic Sarcoma of Liver.

DR. BURGEN read notes of the following cases:—1. The Gastro-intestinal Form of Renal Calculus; 2. Pernicious Anæmia.

DR. SINCLAIR WHITE exhibited and made remarks on the following specimens:—1. Aneurysm of the commencement of the right common carotid for which distal ligation of the carotid and subclavian had been unsuccessfully practised, the patient eventually dying of exhaustion incidental to proximal ligation. The case was interesting on account of the absence of an aneurysmal pulse, sphygmographic tracings taken from both common carotids showing no appreciable differences. The aneurysmal tumour, which was of the size of a turkey's egg, caused no pressure symptoms beyond contraction of the right pupil, and there was entire absence of a thrill and bruit. The patient was a retired soldier, *æt.* 40, and had had syphilis. 2. Resection of the transverse colon and a portion of the small intestine for a rapidly growing malignant tumour of the omentum in a man, *æt.* 24. The patient had made an excellent recovery from the operation, but as a number of infected mesenteric glands were unavoidably left speedy recurrence was anticipated. 3. Excised chronic ulcer from the stomach of a man, *æt.* 52. The history dated back four years, and the patient had become much emaciated and was no longer able to work. The ulcer was situated at the upper and back part of the stomach near the pyloric end, and measured one inch in diameter. It had almost eaten through the stomach walls, and was surrounded by extensive adhesions. The patient had made a good recovery and was getting strong again. A noteworthy feature in the case was the advent of

alarming hæmorrhage after inflation of the stomach for diagnostic purposes, although previously there had been no hæmatemesis. 4. Resection of small intestine for a round-celled sarcoma that had produced obstruction. The patient was a female, æt. 52. The operation was followed by death from shock.

#### TREATMENT OF CONSUMPTION BY FORMIC ALDEHYDE.

Dr. J. SOBLEY read some notes of a personal interview he had during the summer with Mr. Crôte, the founder of a comparatively recent method of treating consumption practised in Paris. The method consists in the transfusion of a specially-prepared solution of formic aldehyde into the tissues of the body by means of a very powerful static machine. The method has at least a certain amount of probability as regards its efficacy, and some of Crôte's principles have been confirmed by independent observers. A needless amount of secrecy, however, surrounds the nature of the formic aldehyde solution, and the method, until the former is published in full to the world, cannot but be tainted with a suspicion of quackery. The examination and treatment of patients seem to be conducted on sufficiently rigid lines, and their statistics are, if true, little short of marvellous. The treatment is in operation in Paris, Bonn, and New York.

## France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, December 16th, 1901.

#### CÆSARIAN SECTION FOLLOWED BY HYSTERECTOMY.

At the Académie de Médecine, M. Ribes communicated the case of a woman, æt. 26, on whom was practised the Cæsarian operation, followed by hysterectomy, delivery being otherwise rendered impossible from the presence of a large number of hydatid cysts. The operation was successful, both as regards the mother and child.

#### POTATOES AND DIABETES.

M. Moesse read a paper in which he related a certain number of cases proving that in the treatment of different varieties of diabetes and its complications, potatoes might be substituted with advantage for bread. Yet he was of the opinion that the cure by potatoes, which was equivalent to the alkaline cure by reason of the potash they contained, should not be prescribed in all cases without distinction, and especially so in patients suffering from chronic nephritis, the potash increasing the toxic condition of the blood.

#### DIAGNOSIS OF TRAUMATISM OF THE SKULL.

M. Poirier spoke at the Société de Chirurgie of a patient who, having fallen from a height, was carried to his ward. The idea of meningitis suggested itself at first, but such was not the case, as was proved by a puncture in the lumbar region, which was followed by a flow of blood-coloured liquid, and in a day or two by the presence of local and sub-conjunctival ecchymosis; it was evidently a case of fracture of the skull. What was particularly interesting in the case was that the lumbar puncture produced an immediate improvement in the patient, such that he was able to leave the hospital after a few days.

M. Rochard said that he had employed the lumbar puncture in three cases of cranial traumatism. In one case, that of a child, the liquid was projected with such force that it was all lost, and it was impossible to notice if it contained blood; but the condition of the patient was immediately improved. A similar result was obtained in another case.

#### SPLENECTOMY FOR RUPTURE OF THE SPLEEN.

M. Richelot reported a case of rupture of the spleen

followed by slow hæmorrhage and treated with success by splenectomy. It was that of a woman, æt. 50, presenting in the left hypochondrium a considerable tumefaction which seemed to have developed slowly, and progressively. Believing at first that it was a case of hydronephrosis he made a lumbar incision, which showed him a small kidney, but of normal appearance. He closed the wound and performed laparotomy, and fell on a large collection of blood, the origin of which he found on the under edge of the spleen, where there was a loss of substance. He removed the spleen, and the patient made a good recovery.

#### TREATMENT OF ACUTE DYSENTERY BY OXYGENATED WATER.

The important rôle of antiseptic enemata in the treatment of dysentery is well known. Among the agents usually employed may be mentioned nitrate of silver, recommended by Trouseau, permanganate of potassium, ichthyol, methylene blue, &c. According to Dr. Rocanz, of the Children's Hospital at Bordeaux, oxygen water constituted a valuable remedy in the dysentery troubles of children. He had an opportunity of trying the agent in an epidemic of dysentery in a dozen children of from two to twelve years old. He employed the oxygenated water at twelve volumes, and diluted with five times its volume of warm boiled water (oxygenated water, 5ij; sterilised water, 3x). The quantity of the liquid injected varied with the age of the patient, and also with the tolerance of the colon. In all the cases treated the state of the patients improved rapidly.

#### THE THERAPEUTICS OF SUPERHEATED AIR.

Dr. Gariel presented at the November meeting of the Académie de Médecine, in the name of Dr. Ostwal, four patients cured by the therapeutical application of a physical agent. The agent in question was the local bath of superheated air according to the Tallerman method, originated some years ago in England. The cases included:—Double sciatica of eighteen months duration, cured at the nineteenth sitting; chronic articular rheumatism of more than two years standing, cured at the tenth sitting; inflammation of the knee-joint without effusion, very marked improvement; and chronic multi-articular gout, which began a year ago, and has been extending for six months—cure very rapid, treatment prolonged to twenty sittings to guard against a return.

Dr. Landouzy observed that for more than five years he had availed himself of the Tallerman superheated air treatment in his wards at the Laennec Hospital with great success in sub-acute and chronic affections of the joints, and notably in cases of gonorrhœal rheumatism, in which it appears to him the best of all possible methods of treatment.

## Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, Dec. 14th, 1901.

#### ELEPHANTIASIS.

FAVARGE, at the "Gesellschaft," showed a farmer, æt. 26, from Grundsee, in Styria, with a monstrous form of elephantiasis. The peripheral left thigh measured 124 centimetres (48.818 inches) while his waist only 82 centimetres, or 32.283 inches. The skin was covered with a horny scurf that could be easily

rubbed off. The patient had never travelled beyond his own neighbourhood until constrained to do so by the necessity of seeking relief from his distressing malady. It appears to be a non-tropical sporadic form of the disease which from the history had taken about eight years to develop. Favarger gave it as his opinion that the aetiology might be due to *concretio pericardii cum corde*, or some other affection of the heart with repeated attacks of erysipelas or erysipeloid skin affection. Lymphorrhœa or chyluria had never at any time been observed.

#### A TEST APPARATUS FOR FÆCES.

Zweig commenced his demonstration of an instrument for separating undigested fibre from the fæces. He drew attention to the difference in digestion of fibrous tissue and muscular tissue when exposed to artificial digestives, the former breaking up in two hours while the latter required twenty-four hours. The conditions were inverted, when the albuminoid was brought in contact with the pancreatic fluid. This fact has led to the physiological examination of the fæces as the most trustworthy test of the digestive function, with Boar's faecal sieve, which is a spheroidal ball separable at the equator, and containing fine wire to catch the undigested fibres. The ball has fine openings at both poles for the admission and egress of pure water for washing the *débris* when charged. The patient is first prepared and then given a lightly cooked beefsteak. The next two stools are put in the sieve, washed, weighed, and carefully examined, which, with the history of the case, gives a fair knowledge of any morbid changes in the alimentary tract.

#### TRAUMATIC CARDIAC HYPERTROPHY.

Benedikt demonstrated the Röntgen photograph of the patient he showed at the last meeting, who fell from a scaffold and who, six months after, was found to be suffering from aortitis acuta and hypertrophy of the heart, which had since receded. Since the last meeting the patient had died. The post-mortem examination confirmed the diagnosis of aortitis acuta with cardiac hypertrophy.

Braun repeated that the correct diagnosis of such a case was a very difficult undertaking. As Hirsch had pointed out the anatomical diagnosis of the heart did not depend on a simple examination of its walls or bulk, but on its anatomical weight after the pericardium and auricles are removed, as the thickness of the wall depends very much on the mode of death, whether in systole or diastole, which considerably alters the general appearance and bulk of the organ. It would seem from evidence of Benedikt's case that the arterio-sclerosis was not the cause of cardiac hypertrophy.

#### COVERINGS FOR SCARS.

Hennig showed a contrivance for covering scars or other cosmetic defects, which had the advantage of allowing free movement for air and moisture, which have been the defects hitherto met with in this cosmetic requisite. Small noses or ears can be enlarged at will and appear perfectly natural.

#### MIRBAN OIL OR NITROBENZOL POISONING.

At the Budapesth "Vereine" Jassinger related a case of poisoning with a few drops of nitrobenzol. The patient, æt. 32, was an operative in one of the cleaning industries. Immediately after swallowing the poison he was seized with fainting fits and cyanosis. Medical aid

was soon obtained, and the patient recovered, although it was rapidly succeeded by papillitis and changes in the blood, the corpuscles being macrocystic, with nuclei in the red blood corpuscles or the degeneration phenomenon; the colour was reduced, and the plasma refracted the rings after the red blood corpuscles were removed. The blood, therefore, had the property of both degeneration and regeneration.

#### VASELINE INJECTIONS.

Notwithstanding the danger Gersuny pointed out some time ago in a case that died suddenly after injection of vaseline, Hercyl claims credit for the few cases he brought before the society as an example of his success without any untoward symptoms to mar the efficiency of the treatment. The first was a vesico-vaginal fistula, which he closed after ten sittings. Another of his cases was prolapse of the rectum, which was perfectly cured. Many other operations of a cosmetic nature were shown, such as saddle nose, shrunken glands, &c., &c.

#### TUBERCULOSIS.

Struppler records a case of tuberculosis he was attending in which the patient died rather unexpectedly with perforation of the pylorus. The patient was a young man, æt. 18, who was suffering from tuberculosis of the lung with a little tenderness on pressure over the pyloric region. He died suddenly after an attack of pain in the bowel. Post-mortem examination revealed a hole measuring 2.5 centimetres across on the smaller curvature of the pylorus, with a circular ulcer running round the bowel. Towards the duodenum a ridge of mucous membrane 2 mm. wide lay detached. The ulcer had sharp edges, with fine tubercles strewn through its texture, and a quantity of cheesy matter. This portion lay in front of the stomach, and for 8 mm. around was covered with fibrin.

Such ulcus tuberculosis serpens must be due to auto-infection by coughing it from the lung and then swallowing it, as the ulceration must have been of recent date, since there were no adhesions or swellings of the mesenteric glands. It cannot be attributed to a hæmogenic origin, as there was no evidence of miliary tuberculosis.

#### BACILLI IN SPUTUM.

Since the observations of Hesse, that the bacilli in sputum increased in Heyden's media after incubation, very little information has been forthcoming thereof. Gähtgens has repeated the experiments on different media, and confirms the increase in number without any obvious change in the first bacilli observed. He has taken the sputum alone and examined it, then put it in an incubator for six or eight hours, when the increase will be found to be enormous. This must be considered a very serious matter in large communities, where the sputum has every opportunity to germinate.

## The Operating Theatres.

### WEST LONDON HOSPITAL.

ILEO-COLOSTOMY FOR MALIGNANT DISEASE OF THE CÆCUM.—Mr. SWINFORD EDWARDS operated on a man, æt. about 40, who had been admitted for a tumour on the right side of the abdomen, with the following history. He had three months before noticed a swelling in his side for which he had sought relief at a hospital. The surgeon under whose care he came, imagining it was



a swelling of the kidney he had to deal with, explored the right kidney by a lumbar incision. In doing this he inadvertently opened the peritoneum and then found that the tumour was not connected with the kidney, but appeared to be a malignant growth of the cæcum. The wounds were then stitched up, and the tumour was left to be dealt with on some future occasion. The symptoms the patient presented on coming to the West London Hospital were diarrhoea alternating with constipation, but no melaena nor any particular pain; there was a sinus in the lumbar region in the site of the former wound which had not completely healed. The swelling in the right flank was distinctly marked and apparently fixed. An incision was made in the right semilunar line through the abdominal parietes, when what appeared to be a malignant growth of the cæcum was exposed. It completely encircled the bowel at about the junction of the cæcum and ascending colon. It was tightly bound down behind, owing, no doubt, to the previous operation. As, owing to these extreme adhesions, colectomy seemed out of the question, Mr. Edwards elected to do a lateral anastomosis between the lower part of the ileum and the transverse colon; this was effected by means of a Mayo Robson bone bobbin in the following manner:—A purse string suture was introduced into the small intestine first, the bone bobbin then inserted and the suture tied tightly; this was repeated in the transverse colon, and to fortify this a series of Halsted's sutures were introduced into the apposing surfaces of the ileum, and transverse colon, completely encircling the opening, and the abdominal wound was finally closed in layers, and the patient removed. Mr. Edwards said that although occlusion of the bowel had evidently not taken place at the site of the tumour, for he could make his little fingers meet through the malignant growth by invagination of the bowel above and below the stricture, yet it appeared that this would probably soon have resulted, and as he did not feel justified in attempting to remove the carcinomatous mass he concluded that the best thing he could do under the circumstances was to short circuit the intestine in the manner he had done. With regard to the original diagnosis he said he did not think that any blame could be attached to the surgeon for having mistaken this tumour of the colon for an enlarged kidney, for at that time there were no bowel symptoms, and the pain the patient then complained of appeared to have been somewhat characteristic of renal pain, though Mr. Edwards was unable to learn that there had been any deposit of either blood or pus in the urine.

Ten days after operation the abdominal wound was healed, the patient's bowels were acting comfortably, and he was already taking semi solid food.

#### ROYAL FREE HOSPITAL.

**OPERATION FOR RUPTURED HYDRO-NEPHROSIS.**—Mr E. W. ROUGHTON operated on a boy, *æt.* 5, who had been admitted on account of hæmaturia following a fall three days previously. On admission examination of the abdomen was negative; the child had hæmaturia, but in every other respect was normal. After three days in hospital the hæmaturia ceased suddenly, and a tumour the size of a child's head developed in the left kidney region. Mr. Roughton then made the diagnosis of a ruptured pelvis of the kidney, with blockage

of the ureter by clot, and consequently extravasation of urine in the neighbourhood of the kidney; therefore, he decided to operate. He exposed the swelling through an oblique incision extending from the anterior-superior spine to the angle between the last rib and the erector spinæ, dividing all the abdominal layers till reaching the peritoneum, which was pushed forward. The swelling proved to be an enormously dilated pelvis of the kidney (which, as he pointed out, is really hydronephrosis); it contained a pint and a-half of blood-stained urine; this being evacuated by puncture, the dilated pelvis of the kidney was freely opened; it was then found that on the anterior aspect of the hydronephrosis there was a rent nearly two inches long. The important point about this, Mr. Roughton remarked was, that the peritoneum over the rent was intact, so that there had been no extravasation of urine. There was very little kidney tissue left, consequently he decided to remove the organ. On removing the kidney, and about an inch of the ureter, he found that at the junction of the kidney and ureter there was a narrowing which would barely admit a probe, this evidently being the cause of the hydronephrosis. The external wound was closed and a drain left in. Mr. Roughton said that the points about the case were, in the first place, the diagnosis on admission, when there was simply hæmaturia, nothing could be made out on examination of the abdomen, this leading at first to the thought of ruptured bladder, which was negated by the passage of a catheter, when two or three ounces of blood stained urine were drawn off. In the absence of any definite symptoms to afford an accurate diagnosis, it was decided to wait and watch the turn of events. When hæmaturia ceased and an abdominal swelling in the kidney region developed, it became obvious that the urine from the left kidney was not passing into the bladder, and that this was due in some way to an injury; what it was at that time he was unable to say, but the operation made it quite obvious that the narrowed orifice of the ureter was occluded by a clot, thus causing the sudden development of a tumour in the kidney region coincidentally with cessation of hæmaturia. On removing the kidney the condition of the pelvis and ureter made it quite clear that he had had to deal with a case of congenital hydronephrosis, which had been ruptured by the fall. He thought it wiser to remove the kidney rather than drain it, because there was very little kidney tissue remaining, and on account of the extensive laceration of the pelvis, if the kidney had been left he considered that a permanent urinary fistula would have almost certainly resulted.

Ten days after operation the child was convalescent, the wound being healed, and the other kidney working well.

#### The Mortality in Foreign Cities.

THE following are the latest official returns, and represent the last weekly death-rate per 1,000 of several of the populations:—Calcutta 31, Bombay 52, Madras 71, Paris 19, Brussels 16, Amsterdam 11, Copenhagen 16, Stockholm 16, Christiania 11, St. Petersburg 22, Moscow 22, Hamburg 16, Munich 22, Vienna 17, Prague 22, Buda-Pesth 16, Trieste 24, Rome 17, Venice 18, Cairo 33, Alexandria 32, New York (including Brooklyn) 16, Philadelphia 15.

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WEDNESDAY, DECEMBER 18, 1901.

**DOES ANTI-DIPHTHERITIC SERUM INFLUENCE DIPHTHERIA MORTALITY?**

A SUFFICIENT period of time has elapsed since the anti-diphtheritic serum came into general use to render it possible to gauge the results by the statistical method. It may be urged that this method has over and over again been employed with results almost uniformly in favour of the therapeutical value of this treatment, but if we look into the matter more closely it will be apparent that the case mortality alone during a given period does not afford trustworthy data for a final opinion. It must be borne in mind that the proportional mortality of diphtheria, as with most other infectious diseases, varies within wide limits in virtue of causes which are still ill-understood. It behoves us therefore to be on our guard against fallacies such as would result from our forthwith attributing reduction in the total or proportional mortality to the influence of any particular method of treatment. A highly important article on the influence of treatment on the oscillations in diphtheria mortality appeared in last Wednesday's issue of *La Semaine Médicale*, from the pen of Dr. G. de Maurans. The author had in view to compare the case mortality of diphtheria in the principal cities of the world before and after the introduction of the serum treatment, in order to establish the influence of the latter. He found himself confronted with the difficulty that in very few instances did the notification returns afford trustworthy information as to the number of cases of the disease, so that he was fain to abandon the idea. The author, therefore, falls back on the total mortality, and establishes in graphic form a series of comparisons which, he suggests, throw doubt upon the direct influence of the serum treatment in lessening the mortality. The tables of curves illustrating the incidence of the disease in various cities at different periods show very clearly that diphtheria

everywhere proceeds by fits and starts. Each outbreak follows an ascensional course, reaching its acme in about three years, and then gradually falls until it reaches a minimum, where it remains for a variable period. When we compare the curves of cities as far apart as Paris and Berlin, Amsterdam and Geneva, we see at a glance that the maximal and minimal dates for any one city are quite independent of those of others, and, what is of even greater significance, of the introduction of the serum treatment. These same curves show however that the great wave of diphtheria which traversed Europe between 1887 and 1893 reached its apogee at some point between those years, and, with one or two exceptions, the curves have since more or less been steadily downward, all subsequent maxima being at a point far below those of previous years. It must be admitted that in most instances the descent set in before the introduction of serum treatment, and followed a course, roughly speaking, the same as at similar previous periods. The exceptions are Glasgow in 1894, Dublin in 1897, Stockholm in 1898, Bucharest and Liverpool in 1899. In one or two instances the author found it possible to establish the proportional mortality of diphtheria in regard to the total number of cases, and from the fact that this varied within wide limits he infers that the serum treatment was without influence on that mortality, an assumption which does not commend itself for acceptance since it is recognised that the virulence of the disease varies within wide limits in different epidemics and at different periods of the same epidemic. It is therefore unreasonable to expect that the effect of any particular treatment, as measured by the proportional mortality, will be equally efficacious—i.e., will keep the mortality at about the same proportional level. This is well shown by the fact that while in 1895 the case mortality from diphtheria in Paris during the first eleven months was 9.42 per cent. (3,842 declarations with 362 deaths), that during the corresponding period of the present year was 14.49 per cent. (4,347 declarations with 630 deaths), that is to say, with 505 declarations more the deaths were in an excess of 268. It would seem that since 1887-1893 the total mortality from diphtheria all over the world has been progressively, and, in most instances, rapidly, diminishing. It may consequently be maintained with some show of reason that the serum treatment at most has but accentuated a natural decrease in that mortality, and, that it does not prevent a comparatively high rate of mortality at seasons of epidemic virulence.

**PULMONARY PHTHISIS IN GENERAL HOSPITALS.**

MORE than fifty years ago Sir Thomas Watson, in his admirable lectures on the Practice of Medicine, said:—"There are many diseases also over which medicine has very little control, but the causes of which, when ascertained, may be avoided or extin-

guished. Such causes, when they do not happen to be removable by individual efforts, are often susceptible of extinction by the united measures of a community; and for this reason it is very desirable that correct opinions respecting the causes of disease should be widely diffused among the public." These words might well be taken to-day as the text for the crusade against pulmonary tuberculosis, but we fear that here, as elsewhere, the practice falls far short of the ideals preached. Over and over again the dangers of treating patients with phthisis in the general wards of our hospitals have been pointed out, but still little or nothing is done to put an end to the practice. Dr. William Stone, in a recent number of an American contemporary, states that the medical wards of the municipal hospitals of New York are still crowded with phthisical patients, and quotes two cases, in each of which a patient admitted with healthy lungs, while undergoing prolonged treatment in hospital, became infected with, and died of, acute miliary tuberculosis. That similar cases may occur in our own hospitals cannot be doubted, and that such a state of affairs should be possible in the light of our present knowledge reflects the greatest discredit on our hospital management. It is quite beside the point to say that measures are taken to prevent infection, and that such cases are admitted as seldom as possible, for one can never be sure that these measures are always effectual or constantly carried out, while one such case may be a source of the greatest danger to all the other patients in the ward. We can hardly expect ignorant patients to realise the infectious nature of their complaint if they are permitted to mingle with other persons. The only argument which can be urged in defence of the practice is that it is necessary, and that in the present state of our hospitals no other plan can be adopted. Were this true, nothing more could be said, and the present practice would have to be accepted as inevitable. But is it true, and have the hospital authorities made any real effort to find an alternative? If each of the clinical hospitals in our large cities were compelled to open at least one, or possibly two, wards with five or six beds each, exclusively for the treatment of consumptives, the difficulty would in a large measure be solved. Phthisical patients form a considerable proportion of the patients who present themselves for medical treatment in our hospitals, and if these institutions are primarily for the relief of the sick poor, surely it is unfair to exclude a large class. The real difficulty appears to be that any such procedure would in many cases seriously restrict the number of beds available for cases of more interest for clinical instruction. This plan has, however, been carried out in the case of typhus, scarlatina and small-pox, and why should it not be done for phthisis? If the public grants to the hospitals were made to depend on its being done, the difficulty would be solved. If such wards were established, they might be so arranged as to be capable of easy and frequent dis-

infection. Only advanced cases, or those presenting some complication requiring hospital treatment, should be admitted, and the latter only temporarily, for the situation of a city hospital is not suitable for a sanatorium for consumptives. Such patients could at least be impressed with the infectious nature of their disease, and be prevented from becoming a source of danger to their fellow creatures, while at the same time a very serious responsibility would be removed from those who have been constituted their guardians.

#### SMALL-POX AND THE ASYLUMS BOARD HOSPITALS.

THERE can be no more eloquent testimony to the excellence of the hospital accommodation afforded for small-pox patients than the eager way in which sufferers of all classes crowd into those institutions in their time of need. In the long run the popularity of a hospital invariably furnishes an unfailing proof of the fitness or otherwise of that organisation to discharge the functions for which it has been called into existence. It must be borne in mind in considering the case of the public infectious hospitals that all ratepayers have a right to demand admission whatever their position in the social scale, and that no costs are recoverable for such accommodation by the sanitary authorities. It is somewhat amusing under these circumstances to read a letter published recently in the *Daily News* from a correspondent who signs himself "Middle Class." He first admits that prompt removal to the board hospitals, hospital ships, and shelters is, doubtless, in the interests of the general public. On the other hand, he considers the matter from the standpoint of the patient, and asks whether the long journey, the crowded hospital, and the indiscriminate mixture of all sorts and conditions of men among the patients would not considerably lessen the chances of recovery in persons used to a comfortable home. The picture drawn by this correspondent of the fate of the small-pox patient entrusted to the tender mercies of the Metropolitan Asylums Board would do credit to the most realistic pen of modern imaginative literature. He depicts the drive in an ambulance, the weary miles that lie between the comfortable bedroom and the distant shelter; the journey down the Thames; the stay in a crowded hospital, tended by overworked nurses, and surrounded by an atmosphere laden with damp river mists; and, above all, the contact with "tramps and vagrants, who have hitherto been the chief victims of the disease." This communication has a distinct value as indicating the somewhat hazy view held by many worthy middle-class persons with regard to the whole question of small-pox and its prevention. The system now being applied in London is the most perfect that the world has hitherto seen. There is no compulsion, however, as "Middle Class" appears to imagine, for patients to go to the public hospitals, save and except in the case of "any person who is suffering from any dangerous

infectious disorder, and is without proper lodging or accommodation, or lodged in a room occupied by more than one family, or is an inmate of any common lodging house, or is on board any ship or vessel may be compulsorily removed by the local authority." The later legal decisions have narrowed down the words "without proper lodging or accommodation" in such a way that under certain circumstances they bring compulsion to bear upon members of the middle and upper classes. The words are now interpreted as having reference to the unfitness of the lodging or accommodation for the reception and treatment of a case of infectious illness, and to the possible danger to others from inadequate isolation of a case. To take an illustration, suppose a well-to-do person living in an hotel or in furnished apartments to be attacked with small-pox, he could forthwith be compulsorily removed by the authorities to a public infectious hospital. From an impersonal point of view there can be no doubt that such a removal would be in the interests not only of the public but also of the patient himself. As to the distance of the hospitals from the main mass of the citizens in a great city that drawback arises from the inherent circumstances of the case. There is great difficulty in finding sites for infectious hospitals, as the proposal to erect such a building is usually enough to set all the inhabitants of the district selected up in arms. Moreover, there are strong reasons for placing small-pox hospitals as far as may be away from centres of population. As regards the risks of transportation, of residence in the hospital wards, and of the river and other items of special environment the answer is to be found in the fact that the total average mortality for the last twenty years of patients treated in the Asylums Board hospitals has been only 16.53 per cent., as against 6.07 for scarlet fever, 19.68 for diphtheria, 20.54 for typhus, and 18.44 for enteric fever. There can be no doubt that the small-pox mortality would have been still further lessened by efficient vaccination, but as it stands the figures are satisfactory in connection with so serious an infection. The risks of ambulance and of hospital isolation, therefore, cannot be regarded as of any great importance. As to the social aspects of the case, they can hardly be taken into consideration. Small-pox is no respecter of persons, and the public accommodation is or should be good enough for all classes. For those who wish special hospital accommodation several excellent private institutions are always available. There is something to be said in favour of special hospital accommodation in public hospitals for paying patients, but on the other hand the subject is surrounded with many difficulties. On the whole the safest principle is to safeguard the interests of the many by making good and adequate infectious disease hospital provision without any distinction of class or acceptance of fee. The right to the general treatment provided is shared in common by all ratepayers just as the resulting benefits in the pre-

vention of disease are conferred upon all classes of society. Some day the whole of our medical charities may be absorbed in some scheme of public administration on lines similar to the institutions so ably controlled by the Metropolitan Asylums Board.

### Notes on Current Topics.

#### The Election of Direct Representatives.

THE election of direct representatives for England and Wales has resulted in the return of Mr. GEORGE JACKSON and Mr. GEORGE BROWN, Dr. Woodcock following at a respectful distance, and Dr. Hayward in the far rear. The most unsatisfactory feature of the election is the indifference of so large a proportion of practitioners to the matters at issue, the abstentions on this occasion having been much more numerous than at the 1896 election, amounting indeed to nearly sixty per cent. This indifference, no doubt, is mainly due to the general feeling that the small number of direct representatives can do little in the direction of reform in the General Medical Council as at present constituted. A study of the proceedings of the Council since the introduction of this new element would show, however, that this belief is founded on error, for influence is by no means in direct proportion to numbers. It cannot be questioned that since the advent of the direct representatives on the Council the interests of practitioners have received a much larger share of attention, and in the person of Mr. Horsley substantial reforms have been initiated in the financial and legal administration of the Council and in other directions. One great obstacle to moving the profession in view of these elections is the difficulty of getting into touch with more than an infinitesimal fraction of a constituency. Be the candidate never so active, he can but address directly a few hundreds out of as many thousands; and even the addresses printed in the medical journals are read, it is to be feared, by only a minority of the electors, so many of whom do not find time to keep themselves *au courant* with the varying phases of medical politics. Be the explanation what it may, the prevailing indifference cannot but have a damaging effect on the principle of direct representation, and will enhance the difficulty of increasing the elective element on the Council.

#### The Physiology of Cycling.

ONE of the principal physical advantages of the cycle is that it enables one to obtain exercise without fatigue, though, of course, fatigue can be had for the asking. This assumption has recently been verified by an ingenious German physiologist, Dr. L. Zuntz, who took the trouble to collect the air expired by a cyclist for analysis. He found that when travelling at the rate of fifteen kilometres an hour the energy expended by the cyclist is 10 per cent. in excess of that liberated by a pedestrian walking at the rate of six kilometres an hour, while at twenty kilometres an hour the energy expended is close upon twice as

great as that of the six kilometre an hour pedestrian. This extraordinary consumption of energy, associated as it is with comparatively slight fatigue, indicates cycling as the pastime *par excellence* for the obese. In common with most forms of muscular exercise cycling diminishes the amount of sugar in the urine of diabetes; and in moderate degrees of anæmia cycling markedly stimulates hæmatosis by actuating metabolism. Its usefulness in the latter direction is limited by the ability of the weakened organism to have recourse thereto. Speaking generally, whenever a person is strong enough to take walking exercise moderate indulgence on the cycle is permissible, not excepting persons suffering from heart disease, other than aortic, who are able to ride. Learning to ride is quite another matter, and it presents special dangers to cardiac and elderly persons on account of the excitement and risk of physical injury associated with the first attempts at attaining equilibrium on wheels. We hear little nowadays of injuries of joints, &c., as the direct consequence of cycling, as distinguished from falls, and it may safely be assumed that the cases placed on record were those of persons predisposed to arthritis. Nevertheless, faulty position may in certain subjects determine more or less troublesome disturbance of function. A pedal out of the true, for instance, may throw an intolerable strain on the ligaments of the knee-joint, just as an ill-shapen or ill-placed saddle may determine genito-urinary trouble. These, however, are not drawbacks inherent to cycling, any more than the prostration which results from immoderate feats of endurance or speed.

#### Methylated Liniments.

WHEN soap liniment is prescribed, the chemist who dispensed liniment made with methylated spirit would unquestionably expose himself to a prosecution for having sold an article not of the nature, quality, and substance demanded, because, unless otherwise specified, preparations embodied in prescriptions should conform to the official description. Whether, when an ordinary customer asks for soap liniment and is supplied with the methylated article at a price in proportion to its quality the dispenser is liable to prosecution is a point which has recently been raised at the Clerkenwell Police Court, the defendants being Parkes' Drug Stores. Similar proceedings against "Boots, Cash Chemists" a few days earlier resulted in a conviction, followed by a fine of £20 and heavy costs. A case has been applied for in respect of the latter, so that we may hope to have the point authoritatively decided. Incidentally a nice point of law was raised, viz., whether a limited liability company could be convicted under the Acts. If they cannot the law would to a great extent become nugatory, seeing that retail pharmacy is fast being monopolised by such companies. With respect to the therapeutical aspect of the case, of course, it matters nothing whether the pure or the methylated spirit be used in the preparation of medicines for external application so that the prejudice to the cus-

tomers, if any, would be merely in connection with the price charged. It is, indeed, rather surprising that the Pharmacopœia Committee should not have authorised the use of the cheaper article under a suitable distinctive denomination. That methylated spirit should ever be used in preparations for internal use is altogether inadmissible in view of the disagreeable taste of the impure spirit. It is well that the question should be thoroughly threshed out, and this is now in process of accomplishment.

#### Poaching by Public Vaccinators.

UNDER pretext of placing the services of public vaccinators at the disposal of the public many districts of the Metropolis and elsewhere have been inundated with posters and leaflets bearing in large type the names and addresses of these officers, conveying the intimation that anyone can be vaccinated *gratis* with Government lymph. Not content with exhibiting these bills in every prominent spot, the handbills have been left at all the houses in the respective districts, of rich and poor alike. No wonder that protests are making themselves heard against a practice which is in every respect as objectionable as that alleged against the medical officers of medical aid associations. Moreover, by inciting persons who are willing to pay to be vaccinated free of charge an unnecessary burden is thrown on the ratepayers. It must be borne in mind that the public vaccinator is invariably engaged in private practice and is directly interested in this wholesale advertisement. The leaflets in question are usually signed by the Clerk to the Guardians, and are issued, it is asserted, in conformity with the regulations of the Local Government Board. Surely, however, it would suffice for the officer to be designated as the Public Vaccinator without giving his name? In any case, the practice is one which has very naturally excited much feeling on the part of private practitioners and urgently calls for repression.

#### The Macclesfield Dilemma.

MISS MURDOCK CLARKE, the resident officer at the Macclesfield Infirmary, having decided not to resign, the Governors in their turn have declined to dismiss her, although they have agreed to release her from her promise to remain twelve months. An appeal was made to the honorary staff to withdraw their resignations, and matters therefore remain in the state *quo ante bellum*. The medical staff cannot well recede from the position they have taken up and, on the other hand, Miss Clarke cannot carry on the work of the infirmary single-handed. It is extremely unlikely that other practitioners will step in to stop the gaps, and it is inconceivable that an important medical charity should continue to suffer from the internecine conflict. With every sympathy for Miss Clarke, who plays the *role* of the Turk's head in this unfortunate controversy, we cannot help thinking that it would be becoming if she consented to place the interests of her patients before her own and vacated an untenable position.

### The Proposed Reforms in the Royal Army Medical Corps.

A GENTLEMAN, described as a high authority, has sent from Germany various suggestions and criticisms on the proposed reforms in the Army Medical Service to the current number of *The Outlook*. Perhaps the two most important points in the paper are his proposals with regard to the Advisory Board and his suggestions for obtaining the required number of suitable candidates. With regard to the former of these, he suggests that appointments to the posts of consulting physicians and surgeons to the Army should already be made in times of peace by the Crown, acting on the advice of the Secretary of State or director-general, such appointments being honorary and given to the most eminent practitioners and scientists of the day throughout the whole kingdom. In times of war, only such men who have held the appointment should become eligible for active service. By this means the director-general would have a staff of the most prominent men throughout the whole country at his disposal who might be called upon to serve on the Advisory Board for certain periods, or in any other capacity in connection with the R.A.M.C. In order to attract a greater number of candidates certain inducements should be held out to them at the very outset of their career. The writer proposes a system of scholarships similar to those in vogue in the German service. Candidates entering the Friedrich Wilhelm's Institut at Berlin receive board and lodging there and their full medical education at the Berlin University gratis. Before taking their final degree, they become attached to a main hospital of the medical school (Charité) for a year, during which they act as resident medical sub-officers in the various wards. After the ordinary term of military service (six months for medical students), they join military hospitals for another space of six months. Then they are eligible for the Army Medical Service. If the probationer is found acceptable, his appointment is recommended by the Director-General to the Crown. He engages to remain in the service for a period which bears a certain relation to the time he has had the scholarship. Time of study, as a rule, lasts five years, candidates pledging themselves for ten years' service. Licensed medical practitioners, who have had no scholarships and enter the Army, receive a gratification amounting to £50. The idea of a system by which a large body of medical men throughout the country would be at the call of the War Office when required is by no means a new one. Further, it is one which will probably receive more attention in the future than it has in the past. We are coming to recognise that, in this country it is impossible to maintain a war establishment during peace time. Hitherto the difference between the two establishments has been made up when necessary in a haphazard and put-your-trust-in-Providence kind of manner. We look forward to a definite change in this in all our naval and military departments—a change which will enable the

Government to place themselves in communication with the required men, and to obtain their services as matter of right.

### The General Medical Council and the First Year of Professional Study.

SIR CHRISTOPHER NIXON'S speech at the General Medical Council, when proposing the adoption of the first of the recommendations of the Educational Committee, has secured a large meed of praise even from those who did not altogether agree with the proposals he brought forward. The resolution runs as follows:—That the Council approve of the suggestion that the registration of a medical student should be postponed until he has passed (1) a recognised examination in arts, and (2) a recognised examination conducted by the qualifying bodies in the preliminary scientific subjects, on the understanding that the subsequent course of professional study should occupy at least four academic years. Sir Christopher Nixon argued in favour of such a radical change that the subjects to which the resolution alluded were subjects of general education, subjects to ensure that the student had a broad, general culture; that, in other words, medical education had two sides—the arts side and the scientific side—and that if the Council added to the arts requirements the amount of science training which it required from the student as his first year of study, it would have students with such a broad degree of culture that when they came to medicine they would be capable of taking a broad view of the subject. Sir Christopher Nixon almost, we fancy, succeeded in persuading his hearers that the scheme embodied in the resolution was preferable to the present scheme; he could not, however, succeed in persuading them that it was feasible. A criticism which was passed upon it at the time was that it was a few years too late. If such a proposal had been as clearly laid before the Council at the time of the adoption of the five years' system as it was at the Council's last meeting, there is, we think, little doubt that it would have been carried. Now we fear the licensing bodies and medical schools would look askance at a proposal which would entail an almost complete revision of a lately-revised curriculum. Sir C. Nixon's resolution recommended what was, perhaps, to be regarded as a final attempt to bridge over the difficulties which exist between the Council and the English colleges. For that reason, and in view of the grave doubts which surround an appeal to the Privy Council, it might have been well if the recommendations of the Educational Committee had been adopted.

### Small-pox in London.

THE small-pox epidemic in the metropolis, although it has not, so far, realised the predictions of certain pessimistic health officers, continues steadily to spread. The admissions last week numbered 132 which, if not alarming, is at any rate disquieting.

### The William Smyth Memorial Fund.

WE are glad to be able to state that the William Smyth Memorial Fund is making steady and satisfactory progress. It is especially pleasing to note that subscriptions to it come not alone from all over Ireland, but from all over the British Isles. The efforts of the promoters of the fund and their supporters must not, however, be lessened. The late Dr. Smyth left a widow and family of eight young children behind him, and it will necessitate a continued effort to provide even the minimum sum to support and educate them. We are sure that our readers will agree that this is not a case in which merely the minimum sum necessary to effect the required object should be deemed sufficient. The response to the appeal of the Presidents of the Irish Colleges must be such that ample funds are provided to enable Mrs. Smyth to fight her battle of life untrammelled by harsh and undeserved poverty.

### Inquest on a Mummy.

THE humours of the Coroner's Court are few and far between, inasmuch as they are for the most part possessed of tragedy and gruesome circumstance. American writers have made the most of the coroner who, being paid for each inquest, insists on holding a formal inquiry on every human fragment found within his jurisdiction. In this way an unfortunate engine-driver, blown to fragments by an explosion, has furnished material for a dozen or more inquests in his own district, and for almost as many more in neighbouring counties. The imaginative brain of that type of author, however, has failed to grasp the possibilities opened up by "sitting" upon imported mummies. That stroke of genius was left for an English coroner, Dr. Wynn Westcott, who has achieved thereby a world-wide fame through the agency of the Law Courts. The facts of the case are simple. A benevolent English lady wished to present to the museum of a religious institution in Belgium a Peruvian mummy. After some difficulty she obtained the body of an Inca, a young princess of the Royal family, and this she shipped to England. On reaching Liverpool the mummy was sent by the London and North Western Railway Company. The case was opened, and the contents, which included two ancient skulls and a piece of pottery were damaged. On reaching Belgium the police ordered the burial of the mummy. The London coroner, when informed of the discovery of the body, held an inquest. The solemn verdict of the jury was to the following effect:—"That this woman was found dead at the railway goods station, Sun Street, on April 13th, and did die on some date unknown in some foreign country, probably South America, from some cause unknown. No proofs of a violent death are found, and the body has been dried and buried in some foreign land, probably sun-dried and cave-buried. The jurors are satisfied that the body does not show any recent crime in this country, and that deceased was unknown, and about twenty-five years of age." The mummy was some

400 or 500 years of age, and the plaintiff was awarded £75 damages for injury of goods in transit. These facts suggest a field hitherto unworked by the coroners, for there must be a vast number of mummies in private and public collections scattered through the United Kingdom. Under such circumstances the British Museum might be made as productive as the gold mines of King Premph. If an ancient mummy is to be "sat upon" by the coroner, surely all the fragments of human origin should logically share the same inquisition. It is not likely, however, that so farcical a waste of public funds would be permitted for any length of time. Grotesque inquests of the kind indicated will not add to the dignity of an ancient and honourable court of law.

### An Unsuccessful Claim for Damages.

THE idea of instituting a civil claim for damages on the strength of an alleged criminal assault is peculiar to the English mind, just as is the practice of claiming a pecuniary solatium for a wife's dishonour. An instance of the former procedure came before the Solihull County Court a few days since, when a married woman set up a claim for ten guineas by way of compensation for an assault of which, she alleged, the defendant, Dr. Vincent Hall, has been guilty. She had consulted the defendant in respect of her infertility, and eventually an examination was instituted, which was apparently construed by the plaintiff to have been the assault complained of. Before the evidence had been fully heard the jury returned a verdict for the defendant, with costs on the B scale. Dr. Hall was defended by Mr. F. Colam, on behalf of the Medical Defence Union.

### The Last of the Dog Muzzles.

THE disappearance of rabies from Great Britain must be regarded as a triumph of preventive legislation. That happy result is pretty confidently assumed by the Board of Agriculture, which has accordingly removed the muzzling order from the last remaining counties of Breconshire, Glamorgan-shire, and Carmarthenshire, and has thus released the dogs of the whole of England and Wales. The Board has, moreover, good reason for believing that rabies has now ceased to exist in any part of the United Kingdom. However, as the disease is still common in many parts of the Continent, it is necessary to keep a strict watch upon all dogs entering the United Kingdom from abroad. A new Order has, therefore, been issued under the title of Transportation of Dogs Order of 1901. Its main direction is that after March 13th next every dog so entering shall be detained and isolated at the expense of its owner upon premises in the occupation or under the control of a veterinary surgeon for a period of six months from the date of landing. Licenses are required for each dog upon landing, but special regulations are made for dogs that are merely sent through Great Britain in transit, and for foreign performing dogs. Mr. Long has for some years been the centre of abuse from sentimentalists, who think the comfort of their dogs of

more account than the death-toll of a certain number of their fellow creatures from one of the most terrible of all human maladies. He has, however, by his persistence, achieved a notable success which registers, in point of fact, one of the few solid benefits conferred upon the community during the past few years in the direction of domestic legislation.

#### Forgotten Remedies.

IN looking over a catalogue of foreign medical works, the title of one of them, "Les Remèdes Oubliés," suggested an interesting and possibly instructive train of thought. If the size of the work is at all proportional to the subject of which it treats, it must be a library in itself. Vast as the tomes are that deal with the remedies of the first year of the twentieth century, they are nothing to the stupendous piles of literature dealing with drugs and methods that have outlived their fleeting day. Of the vanished host many have been mere superstitious follies or fantastic fashions, while some few have been rediscovered and flaunt their virtues once again under a new and more or less scientific guise. The present generation has witnessed the rise and fall of scores of these therapeutic shooting stars, and is still doubtless directing its gaze heavenwards at many equally unsubstantial meteors. The commercial side of the question is worthy of careful consideration at the hands of our social philosophers. Vast sums of money have been poured out like water in that direction in foisting not a few of those now forgotten drugs upon the market. Had the drugs been sound and their virtues recognised they would have been adopted by the medical profession quite apart from advertisement. It is safe to say that every really good remedy brought before the notice of medical men sooner or later is bound to be adopted. But in nine cases out of ten they are forgotten, and the list of the forgotten grows even greater with the lapse of years. The moral is that judgment were best suspended as to the value of new remedies, or, to amend the old proverb so as to read "Time tries all — remedies." A work on these forgotten remedies is not without a value of its own. History repeats itself in medical as in other departments of human industry and thought, and a retrospective glance at this forgotten lore would often enable us to avoid misplaced enthusiasm and to discard hopes which experience has already shown to be without foundation.

#### The Concentration Camp Mortality Rates

AFTER considerable delay the concentration camp mortality statistics have been published for the months of October and November. Up to the commencement of that time the figures had been regularly announced, and their abrupt suspension had naturally enough given rise to all kinds of unfavourable comments. The thousand tongues of rumour have now found some sort of justification, inasmuch as the figures just issued are worse than any previously given, a fact that is certainly not calculated to increase the confidence of the public in

the methods and candour of the Government. Miss Hobhouse, had she been allowed to land at the Cape, could not have done more than confirm the terrible mortality rates now officially announced to the world. The rate per 1,000 per annum of deaths of persons of all ages in the camps was 398 in October and 284 in November, as against 109 in June. The death-rate among children was 433 in September, 572 in October, and 469 in November. Such a mortality among non-combatants under British protection points to a deplorable loss of life from more or less preventable causes. The original statements of Miss Hobhouse have been amply confirmed by subsequent Government reports. It is a pity that the vigorous measures now announced as about to be taken to reorganise and reconstruct the camps was not undertaken before attention was drawn to the state of matters by a civilian. The attempt to put off the evil day by withholding information is unworthy of the statesmanship of a great nation.

#### A suggested Electro-Therapeutic Society.

THE suggestion that a new society should be formed for dealing with electro-therapeutics invites some plain speaking on the part of the medical profession. Apart from actual cauterisation and electrolysis, the definitely curative field of electrical treatment is extremely limited. That view may be confirmed by a perusal of a standard work like that of Dr. Lewis Jones, who discusses the subject with moderation and full knowledge. The fact appears to be that the results of medical electricity are not commensurate with the time that method has been before the profession. It may be, of course, that advancing knowledge may bring fresh weapons within the grasp of the medical electrician. Among recent developments, Röntgen ray therapeutics and high frequency current effects certainly suggest a field of unexhausted possibilities. It is tolerably safe to say, however, that within the next ten years Röntgen ray therapeutics will be as dead as Queen Anne, that is to say, unless new and hitherto unsuspected potentialities are meanwhile revealed. The Röntgen Society, in the person of its honorary treasurer, utters the mildest and politest of protests against the formation of a new electro-therapeutic association, and states that it has been for some time under the consideration of his own society to extend the scope of their constitution so as to include radiations and electrical phenomena other than those discovered by Röntgen. The suggestion that the society already established should throw open its doors to the electrical therapeutists seems obviously well founded, that is to say, if any organisation of the kind be really wanted.

THE Prince of Wales's Hospital Fund is expected to benefit by upwards of £25,000 under a bequest in the will of the late Mr. Bernard Hirsch, who died in London last month. A sum of £3,000 also goes to the North London Consumption Hospital and £1,000 to the Hospital for Sick Children under the will.



### Menageries and the Spread of Tuberculosis.

DR. S. A. KNOPF, of New York, has recently drawn attention to the danger of tuberculous infection in childhood from visits to menageries. These greatly loved visits of the little ones should, he thinks, give concern to sanitarians. To visit the monkey-houses in the Zoological Gardens and to remain there as long as nurses, time and temper will allow is the delight of every child. But monkeys also, like the children of men, are prone to tubercle. The commotion, dust, impure air of the average monkey-house are certainly favourable to the dissemination of tubercle. Managers of menageries and directors of zoological gardens should do their utmost to reduce any danger to a minimum.

### Spinal Cocainisation.

OCCASIONAL deaths continue to be recorded from time to time as the result of anæsthesia by means of intra-spinal injections of cocaine. Dr. Legueu, of Paris, related two instructive cases before the French Society of Surgery a few days since. The first victim was an elderly man, who had ruptured the tendon of the triceps. Less than a third of a grain of cocaine was injected, but ten minutes later he became agitated, and died in two or three minutes afterwards. A few weeks later a man, sixty-one years of age, with strangulated hernia, was subjected to a similar injection, and even before anæsthesia was complete, respiration became laboured, the pupils dilated, and death ensued. The moral to be deduced from these cases is that when the condition of the patient contra-indicates the administration of chloroform, resort to spinal cocainisation does not minimise the risks. It would seem, too, that in some of these cases local anæsthesia would have answered every purpose without placing the life of the patient in jeopardy.

### The Notification Responsibilities of Householders.

THE clause in the Notification of Infectious Diseases Act which renders it incumbent on the householders to notify the existence of infectious disease has been allowed to fall into abeyance, and in some cases it has no doubt become the practice to abstain from calling in a medical man in order to be able to plead ignorance of the nature of the disease. We are pleased to see that this plea is not always allowed to protect the delinquents. In a case at Spitalfields last week a man was fined the full penalty for neglecting to notify. As the penalty is only forty shillings it cannot be expected to act as a very efficient deterrent, but it ought, nevertheless, to be rigorously enforced.

### Mosquitos at South Kensington.

UNTIL quite recently the Natural History Museum at South Kensington did not contain any collection of mosquitos worthy of the name, but the deficiency is now rapidly being remedied, extensive collections arriving weekly from every corner of the world. Students of natural history, and those for whom this insect possesses special interest in view of the part it

plays in the dissemination of disease, will henceforth be enabled to pursue their researches without let or hindrance.

### Jews as Doctors.

IT is a significant fact that the great majority of female students at the Continental schools of medicine are Israelites. In Germany and what may be called German Austria the practice of medicine is mainly in the hands of Jews, a large number of the most eminent specialists being of that ilk. In this country medicine has not attracted their attention to anything like the same degree, although here no overt racial prejudice militates against their success.

PROF. BEHRING is reported to have discovered a means of rendering cattle refractory to tuberculosis by inoculations carried out in accordance with Pasteur's method.

### PERSONAL.

PROFESSOR J. STYNGTON has been appointed Registrar of Queen's College, Belfast, in place of Professor Purser, resigned.

MAJOR COURTNEY MANSFIELD, of the Indian Medical Service, has been promoted to the rank of Lieutenant-Colonel for gallant services in China.

DR. McVEAGH sustained severe injuries last week as the result of a fall down stairs. The most recent reports give his condition as precarious.

DR. CHARLES PORTER, Medical Officer of Health for Shropshire, has been selected for the appointment of Medical Officer of Health to the Municipality of Johannesburg. The salary is £2,000 per annum.

It affords us pleasure to announce that Dr. Neil Kerr, assistant to the late Dr. Campbell Clark, Medical Superintendent of the Lanark District Asylum, has been appointed to the senior post in that large and important institution.

DR. T. N. KELYNACK has been appointed Assistant Physician to the Mount Vernon Hospital for Consumption, Hampstead, Northwood, and Fitzroy Square (North London Hospital for Consumption and Diseases of the Chest).

MR. M. A. ADAMS, county analyst for Kent, has been presented with an oil painting of himself, handsomely framed, in recognition of his thirty-seven years' gratuitous services as surgeon to the Kent County Ophthalmic Hospital at Maidstone.

DR. D. A. WELSH, Pathologist to the Royal Infirmary, Edinburgh, has been appointed Professor of Pathology in the University of Sydney, and is to take up the duties of his Chair in March, 1902. Dr. Welsh has an excellent record; he obtained the gold medal in graduation, was the Wightman Prizeman in 1892, and Murchison Memorial Scholar in 1893.

### GENERAL MEDICAL COUNCIL.

THE result of the poll for the election of two direct representatives for England on the General Medical Council is announced by the returning officer, Sir William Turner, to be as follows:—Mr. George Jackson, Plymouth, 6,518; Mr. George Brown, London, 5,569; Dr. S. Woodcock, Manchester, 3,161; Dr. C. W. Hayward, Liverpool, 1,885.

## Scotland.

[FROM OUR OWN CORRESPONDENTS.]

### EDINBURGH HOSPITAL FOR WOMEN AND CHILDREN.

THE twenty-second annual meeting in connection with this institution, which is the only hospital in Edinburgh staffed entirely by medical women, was held on December 8th, under the presidency of Lady Helen Munro Ferguson. The annual report showed that 112 patients had enjoyed the benefits of the hospital. An anonymous donation of £1,000 had been offered on condition that the contributions otherwise should reach £1,000 during the year—a condition which had been fulfilled. The payments by patients amounted to £207, as against £73 last year. The medical officer's report, presented by Dr. Jessie Macgregor, set forth that the number of dispensary patients was 221, and 271 visits were paid at their own homes. The first year of steady work justified the hope of a wide and successful career for the hospital.

### UNIVERSITY COURT OF ST. ANDREWS.

At the last meeting of this body Principal Mackay, LL.D., University College, Dundee, was elected as representative of the University on the General Medical Council for a period of five years, from January 8th, 1902. A letter from Professor Purdie, Professor of Chemistry in the University, offering to the University a gift of £5,000 for the purpose of building and equipping a chemical research department at St. Andrews was read. It was resolved:—"That the University Court accept with gratitude Professor Purdie's generous offer of £5,000 for the purpose of establishing a chemical research department at St. Andrews. The Court agree to the conditions laid down in Professor Purdie's letter, and will transmit a copy of the letter to the Carnegie trustees with a request that they will give their favourable consideration to the scheme. In accepting the gift, the Court desire to record their high appreciation of the spirit which has prompted it, and express the hope that Professor Purdie may hold the Chair of Chemistry for many years to come, so that he may himself see the fruits of his generosity." At the meeting of the General Council of St. Andrews University, questions connected with the arts curriculum were chiefly under discussion, and the only business of medical interest was contained in the report of the Committee on Ordinances. The two Chairs of Anatomy and Physiology have been established, so that the medical school in St. Andrews is now well provided for two years.

### A "CLASS" FOR MIDWIVES.

At Glasgow Small Debt Court recently Sheriff Muir gave decree in an action by a would-be midwife against a Glasgow medical man for repayment of three guineas, which had been paid by pursuer to defender as a fee in connection with a class in midwifery. Apparently the pursuer had answered an advertisement for pupils, and had paid the fee on the understanding that other women were anxious that the class should be started. She, however, turned out to be the only pupil, and stated that instead of gaining instruction her time had been wasted. Her teacher, on the other hand, contended that she had received full and ample instruction. The Sheriff, in granting decree, with expenses, said he had no hesitation in characterising the case as a fraud. If any additional evidence were needed of the necessity for putting the instruction of midwives on some definite foundation surely a case such as this supplies it. It is obviously ridiculous to suppose that any man can give instruction to a class of one for three guineas, and the fact is that the sooner classes for monthly nurses given by private individuals who are responsible to nobody are put a stop to, the better for all concerned.

### EDINBURGH RECTORIAL ELECTION.

Sir Robert Bannatyne Finlay, K.C., M.P., the Attorney-General, has been officially announced as the Unionist candidate for the next Rectorial election. Sir Robert Finlay's legal attainments are too well known to need comment, but it may not be so generally known that he was originally intended for medicine, and, in

fact, graduated in 1863 at Edinburgh University. Thereafter he assisted his father in practice in Trinity, but soon abandoned medicine for the English Bar. His brother is a well-known practitioner in Edinburgh.

### ELECTION OF DIRECT REPRESENTATIVE.

We were enabled to announce unofficially in our last issue the re-election of Dr. Bruce, the sitting member; we now give the official figures of this election:—Dr. Bruce, Dingwall, 975; Dr. Walker, Edinburgh, 854; Dr. Robertson, Glasgow, 618; majority, 121. 1,432 electors did not vote, 250 papers were returned owing to death, change of address, &c., while 28 papers were spoiled.

## Tiberpool.

[FROM OUR OWN CORRESPONDENT.]

### THE SPITTING NUISANCE.

At a meeting of the Liverpool City Council, held on Thursday last, to consider certain proposed extensions of municipal powers, it was proposed, among other things, to add the following clause respecting expectoration in public conveyances and on the sidewalks of the streets:—"Any person who, after being cautioned by a constable or by any officer in uniform of the Corporation, expectorates on any public footwalk, or who after being cautioned by the conductor or any fellow-passenger expectorates in, on, or from any public conveyance, shall be liable to a penalty not exceeding twenty shillings." After a considerable discussion, lasting over an hour and a half, a vote was taken, there being fifty-two votes for and thirty-three against it. The Lord Mayor remarked that the clause required sixty-one votes to carry it. It therefore had to go. Upon the whole, the termination reached was a desirable one, as on the face of it the clause allows one free expectoration on the floor of a tramcar to each person entering. If a man enters twelve conveyances a day he would be entitled to spit once in each of them, as no proceedings would be taken without a previous caution. This we imagine is scarcely what is aimed at by those opposed to the objectionable practice. It would have been better to obtain power to make the offender wipe up the mess with his pocket-handkerchief, even if a first offence, on pain of ejection from the car with loss of his fare. With regard to spitting on the sidewalk, a small stream of water might be kept running in the gutter, into which pedestrians might expectorate. A place for the purpose would then be provided, and offenders might be dealt with for not conforming. Such a stream would also be a trap for flying dust and carry away a very material proportion of it. Sputum containing tubercle bacilli would then be carried off without the possibility of becoming dust, the only form practically in which it is likely to be injurious. As regards the cost of such a stream of water, that concerns City Councils, but it would probably save a large sum annually, and keep the citizens in health.

## Correspondence.

[We do not hold ourselves responsible for the opinions of our correspondents.]

### PRACTICAL ASPECTS OF MEDICAL REFORM.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR.—It must not be forgotten that the powers and functions of the General Medical Council, discussed in your leader of this week, are strictly limited and defined by Act of Parliament; and that however much the qualities of its members might be improved from the point of view of those who crave for reforms advantageous to the rank and file of the profession, no improvement in that respect would bring us any nearer to what is needed, unless at the same time new and greater powers were conferred upon the Council by the legislature. It is, I believe, open to the strictest proof that reform in medical law putting a check upon the grosser forms of unqualified practice, fraud, and quackery would

prove of far greater advantage to the public than to the profession. If the entire unselfishness of the profession in seeking to put an end to the more glaring of the abuses and evils which at present exist cannot be proved, it can at any rate be demonstrated that more stringent laws would act in the main for the benefit of the weak, the afflicted and the helpless, the classes who have most claim upon the guardianship and protection of the State. Reform is worth working for; and being striven for by a profession practically unanimous, would in the end, there can be no doubt, be attained. Who is to organise the profession and make felt its power at once? An organisation exists in the British Medical Association, but practically it has so far accomplished nothing. The Association is virtually nothing more than a co-operative society for the publication of a cheap medical newspaper, out of the profits of which they are now able to offer some slight encouragement to scientific research and to similar objects. Towards achievement of medical reform it has long seemed to me the first step must be reform of the British Medical Association—reform which would enable the power and influence of a great profession to be concentrated upon the object which is of the most vital importance to the vast majority of members, and of almost equal importance to the bulk of the public, for whom the profession exists.

I am, Sir, yours truly,

Dec. 12th, 1901.

UBIQUE.

#### UNTRUSTWORTHY SERUM.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In reading the last volume of the Report of the Indian Plague Commission and the disappointing results of the treatment, our thoughts are naturally carried back to the origin of treating infectious diseases by inoculation. Pasteur was the first to apply that method to the cure of hydrophobia. When Pasteur submitted to the Paris Academy the treatment of rabies by inoculation with bouillon mixed with a piece of spinal cord of a monkey poisoned with rabic virus, he raised a storm of opposition: "Why! That is the way to spread rabies instead of curing it." But the storm was allayed by the reply of some authorities: "Gentlemen, this is not patriotic." Even some years after the inauguration of the treatment, when the Pasteur Institute was at the zenith of its popularity and similar institutions had been established in different countries, some leading clinical teachers and professors of the Paris Faculty continued their dislike of such an institution in their midst. Mais, que voulez vous? Now we find, after the lapse of fifteen years, that hydrophobia in Paris is on the increase—the deaths having risen to the total of 8,079. This is a high price to pay for mistaken patriotism.

2. The *éclat* of the Pasteur's initiative encouraged Koch to announce a cure for tuberculosis with reasonable hope of success, for, whilst we do not know the nature of the poison in the saliva of rabid animals, nor have we separated the micro-organism which causes it, and Pasteur had to rely mainly upon his ingenuity in improving on an old suggestion of Italian physicians, Valli and Tizzoni, Koch had apparently a substantial foundation to build upon; for he had discovered the bacillus which is the cause of tubercle, and then pronounced the dictum:—"Tuberculous bacilli produce toxin (poison) which inflicts injury upon the human organism; the bacilli produce also at the same time a so-called antitoxin (Koch), which destroys the vitality of the bacilli themselves." By separating the two antagonistic elements and by killing and filtering the bacilli and toxin he expected to obtain the pure antidote, which he called tuberculin, as a cure for phthisis. But unfortunately Koch's tuberculin proved to aggravate the disease, causing disseminated tuberculosis, pulmonary cavities, &c. The fault lay in the oracular dictum, which requires facts to be established by proof before building a system upon them.

It by no means follows that, when we have caught a bacillus, we can make a curative bouillon from it.

3. The antidiphtheritic serum treatment belongs to

the same category. In 1884, Klebs discovered a bacillus in the false membrane, of which Löffler made a cultivation, which is called the Löffler bacillus, of which Behring made a serum (called antitoxin) by passing it through horses. This serum obtained, and still enjoys, great popularity in all countries, and has since been the favourite remedy in diphtheria. It is considered a panacea, an unfailing remedy. Now information has reached us from America and Italy of epidemics of fatal tetanus supervening on its employment. Of course some explanation will be forthcoming, but in this connection I should refer the reader to lectures delivered by Professor Kassowicz, of Vienna, and published in THE MEDICAL PRESS AND CIRCULAR, of 1898. Professor Kassowicz's speciality in the University of Vienna is diseases of children. After long trial he found it injurious. He gives us also a glimpse at the means which were employed to hustle the serum into popularity. The advocates of the antitoxin shield it behind vaccination, which only causes prejudice against Jenner's immunisation. Antitoxin has been tried on a large scale as a preventive, when all inoculated passed through a crisis and many of them died. In reading Kassowicz's lectures we are prepared to regard the fatal tetanus epidemics as a sequel of the treatment. Indeed, it is only by the occurrence of such disasters that a popular craze can be cured.

There is a sublime arrogance in the manner in which scientific discussions are conducted in some quarters. Subsequently to Koch's pronouncement at the Tuberculosis Congress in London, Virchow, addressing the Clinical Society in Berlin, said, "For the last ten years I have been teaching that human tuberculosis is quite different from bovine tuberculosis. This view has been brushed aside by Koch's school as of no consideration, and I had to submit. I am not surprised that Koch has now convinced himself of the distinction between the two forms of tuberculosis; for indeed I could never understand how their identity could be maintained." Here we have the veritable Hercules among the Lilliputians, who are screeching at him in their peculiar jargon, which they consider as philosophical inspiration. Poor Hercules has no show.

I am, Sir, yours truly,

M.D.

Edinburgh, December 5th, 1901.

#### THE LATE R. B. ANDERSON FUND.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—With reference to the affairs of the late Mr. R. B. Anderson, it may be within the recollection of your readers that in July last we made an appeal to the profession for subscriptions towards the support of his widow and twin sons. This subscription now amounts to about £20, a very inadequate sum; but the committee feel that it is useless to keep the fund open much longer. It has therefore been decided to close it on Wednesday, January 8th, 1902, and to make an earnest appeal in the meanwhile for further donations. The amount realised will be at once sent out to the Island of Tobago to be used for the benefit of Mrs. Anderson and her two sons, at the discretion of the Warden of that island.

We may add, in view of a rumour which has prevailed that the Civil Rights' Defence Committee was dissolved in consequence of some misconduct on Mr. Anderson's part, that the only reason for the dissolution of that Committee was its failure to collect, in the time given for the purpose, the funds required for the contemplated appeal to the Privy Council.

Donations are to be marked, "for the late R. B. Anderson's Fund," and to be sent, and made payable to, the Manager, Union Bank of London, Chancery Lane, London. They will be duly acknowledged.

We are, Sir, yours truly,

(Signed) STAMFORD, Chairman.

TIMOTHY HOLMES, Hon. Treasurer.

Dec. 9th, 1901.

## Literature.

## TILLEY ON PURULENT NASAL DISCHARGES. (a)

This work contains the subject-matter of a series of three lectures which first appeared in book form about twelve months ago. They are now re-edited, with the addition of six plates and many new illustrations. We can hardly agree that the author has succeeded in his object to present a concise and practical account of chronic suppurative of the nasal accessory cavities, unless he is writing purely for rhinologists. For example, nearly all operations, and even diagnosis, of purulent affections of the middle meatus depend on removal of part or the whole of the middle turbinate bone as a preliminary step, yet we are never told practically how to do it. On p. 73 we read "If it be possible the middle turbinate bone should be divided along the anterior half of its attachment to the outer wall of the nose, by means of Grünwald's forceps, after which the semi-detached portion may be easily removed by means of a wire snare." This is a statement of fact, not a practical description, and an illustration would not have been *de trop*. The operation of passing Hartmann's cannula (which, by-the-by, is not easy, safe, or even always possible) is most carefully described, but this is often most difficult unless the anterior half of the middle turbinate is first removed. Surely, too, the author is in error when he attributes the use of Carmalt Jones' turbinotome to the middle turbinate bone. It is in removal of enlarged inferior bone that it is both quick and easy to use. And why should he give a figure of it when he says there is such danger in using it?

For radically curing antral empyema the author does a modification of Kuster's method; he inserts one or two fine catgut sutures through the margins of the gingivo-labial incision, thus avoiding re-infection from the mouth, and withdraws the packed gauze through the nose on the third day. For chronic empyema of the frontal sinus Kuhnt's operation is modified so as not to have too much noticeable deformity, the author using a special burr, and not removing the entire anterior bony wall. The author takes several liberties with the English language, e.g., p. 20 we read "to cocaine the hypertrophy"; p. 46, "the patient was very intelligent and in no sense a neurotic," and, lastly, p. 70, "It will at once be obvious how inefficiently such an aperture would function for purposes of drainage." The old fashioned word "act" takes up less room and sounds infinitely better. Perhaps some day the author will give us the result of his knowledge and experience in a more complete form.

## NEW BOOKS AND NEW EDITIONS.

The following have been received since the publication of our last list:—

London and Paris: BAILLIÈRE, TINDALL AND COX.

Manual of Diseases of the Eye. Second Edition. By Charles H. May, M.D. With 275 Original Illustrations, including 36 coloured. Pp. 408. Price 5s. 6d. net.

The Cure of the Morphia Habit without Suffering, with a chapter on Believing the Craving for Drink. By Oscar Jennings, M.D., M.R.C.S., of Paris. Pp. 211. Price 3s. 6d.

Sémiologie Pratique des Poux-mons et de la Plevra. Par Henri Barbier, M.D., et Prof. Grancher, M.D. Pp. 252. Price 4 francs.

Edinburgh and London: WILLIAM BLACKWOOD AND SONS.

The End of an Epoch: being the Personal Narrative of Adam Godwin, the Survivor. By A. Lincoln Green. Pp. 391. Price 6s.

CENTRAL LONDON THROAT AND EAR HOSPITAL.

Formulee supplemental to those in the British Pharmacopoeia. Compiled by the Honorary Medical Staff. Pp. 84. Price 1s.

London: J. AND A. CHURCHILL.

Elementary Ophthalmic Hints, including Ophthalmoscopy and Rhinoscopy. By J. Herbert Parsons, B.S., F.R.C.S. Pp. 162. Price 6s. 6d.

Reports of the Society for the Study of Disease in Children. Vol. I. 1900-1901. Pp. 238. Price 13s. 6d.

(a) "Purulent Nasal Discharges, their Diagnosis and Treatment." By Herbert Tilley, M.D., B.S. Lond., F.R.C.S., Surgeon, Throat Hospital, Golden Square, &c., &c. London: H. K. Lewis, 1901. 4s. net.

London: C. W. DEACON AND CO.

Ugly, a Hospital Dog. By Geo. A. R. Dabbs, M.D. Pp. 200. Price 1s.

London: HENRY KIMPTON.

Pharmacopoeia: A Commentary on the British Pharmacopoeia, 1898. Pp. 686, with 46 plates. Price 14s. net.

London: H. K. LEWIS.

A Text-book of Medicine for Students and Practitioners. By Dr. Adolf Strumpel. Third American Edition. Translated by Drs. Vickery and Knapp. With Notes by F. C. Shattuck, A.M., M.D. Pp. 1,242. Price 24s. net.

Philadelphia and London: LIPPINCOTT AND CO.

Photographic Atlas of Diseases of the Skin. By Geo. Hy. Fox, A.M., M.D. Parts VII. to XII.

London: LONGMANS, GREEN AND CO.

The Essentials of Chemical Physiology. By W. D. Halliburton, M.D., F.R.S. Fourth Edition. Pp. 220. Price 5s.

London: MACMILLAN AND CO., LIMITED.

On Disorders of Assimilation, Digestion, &c. By Sir Lauder Brunton, M.D., D.Sc., F.R.S., F.R.C.P. Pp. 495. Price 16s. 6d. net.

London: SWAN SONNENSCHREIN AND CO.

Psychology, Normal and Morbid. By Charles A. Mercier, M.B., M.R.C.P., F.R.C.S. Pp. 518.

## Laboratory Notes.

## NEW TABLOIDS.

AMONG recent additions to the list of "tabloid" preparations of Messrs. Burroughs Wellcome and Co. we may note the Tabloid Galbanum Co., gr. iv. The carminative, antispasmodic, and stimulant properties of this product are well known, though perhaps less frequently made use of now than formerly.

The Tabloids of Ergotin and Strychnine commend themselves for general use in view of the unquestionable advantages attending the association of these two drugs. Each tabloid contains ergotin, gr. iii., with sulphate of strychnine gr.  $\frac{1}{10}$ .

There are two varieties of Tabloid Hyoscine Co., A and B. Tabloid A contains hyoscine hydrobromide gr.  $\frac{1}{100}$ ; morphine sulphate, gr.  $\frac{1}{2}$ , and atropine sulphate, gr.  $\frac{1}{100}$ . Tabloid B contains hyoscine hydrobromide, gr.  $\frac{1}{100}$ ; morphine sulphate gr.  $\frac{1}{2}$ , and atropine sulphate gr.  $\frac{1}{100}$ . The sedative effects of hyoscine in acute mania are well recognised, and the addition of morphine and atropine are stated to enhance these effects.

A further addition to their list of "Tabloid" products is one containing sodium cacodylate gr.  $\frac{1}{2}$ , and another for hypodermic use of the same strength. We need not here insist on the peculiar properties of this compound of arsenic, the therapeutical value whereof is now generally known. In this form accuracy of dosage is ensured, a point of considerable importance in prescribing arsenical preparations; and experience has taught us to rely with confidence on the purity of the products issued by this firm.

The combination of morphine sulphate (gr.  $\frac{1}{10}$ ) with emetine (gr.  $\frac{1}{10}$ ) has been introduced in tabloid form for use in cases where sedative and expectorant effects are desired, as in irritative dry cough. They should be allowed to disintegrate slowly in the mouth in order to obtain the local as well as the constitutional effects. These tabloids are put up in bottles of 100.

Both quinine and camphor are popularly credited with a curative action in coryza and catarrhal states in general. In obedience to the demand, Messrs. Burroughs Wellcome and Co. have prepared tabloids (1) of quinine, gr.  $\frac{1}{2}$ , and camphor, gr.  $\frac{1}{2}$ , and (2) quinine bisulphate, gr.  $\frac{1}{2}$ , camphor, gr.  $\frac{1}{2}$ , and green extract of belladonna, gr.  $\frac{1}{2}$ . The tabloids afford a convenient and accurate means of administering these combinations of drugs.

Among the most recent additions to the list of "Tabloid" products issued by Messrs. Burroughs Wellcome and Co. we note the Tabloid containing perchloride of mercury (gr. 1/16th) and iodide of potassium (gr. 5) for what is known as the "mixed" treatment of syphilis. It is obviously a great advantage in regard to continuity of treatment that the patient should have his medicine in a form which can be carried

in the pocket, and from this point of view the administration of these drugs in tabloid form is preferable.

Messrs. BURROUGHS WELLCOME AND Co. have added to their list of ophthalmic tabloid products a tabloid containing alum (gr. 1/250). This is readily soluble in the lachrymal secretion, and may be inserted into the conjunctival sac or dissolved in a little water for instillation, as preferred.

## Medical News.

### Dinner to Dr. J. Takamine, F.C.S.

DR. TAKAMINE, the discoverer of taka-diastase and adrenalin, who is travelling from the United States to Japan, was entertained to dinner a few days since by a number of medical and chemical friends at the Midland Grand Hotel, N.W. After his health had been drunk, Dr. Takamine acknowledged it in a speech in which he gave some very interesting information on the bearing of the study of medicine on the recent development of Japan. The desire to study medicine brought the younger generation into close touch with Western civilisation, and proved the starting point of a movement which had had for effect to develop Japanese civilisation on the European model. He mentioned that it was while he was studying in Glasgow University that he began the investigation of the rice ferment which resulted in his discovering that the preparation of *sake*, the Japanese rice-beer, did not depend upon the action of a yeast, as in the fermentation of malt, but on a micro-organism which possessed diastase-producing properties. That diastase, which is exceedingly active, is now known as taka-diastase, and is manufactured on a commercial scale. Passing on to his investigations on the suprarenal body he described the method by which he had succeeded in isolating a definite crystalline active principle—adrenalin—which was possessed of remarkable chemical and physiological properties. Dr. Takamine concluded by showing a series of stereopticon views of Japan in natural colours illustrating the beauties of the countries and the manners of its inhabitants. These views and Dr. Takamine's humorous exposition thereof were highly appreciated, and the enjoyment of the evening was enhanced by the music of a select orchestra in an adjoining room.

### Substituting Brandy.

THE vexed question of substituting brandy which was not of the quality and title demanded by the purchaser was again before the law courts last week—this time in the Vice-Chancellor's Court, Dublin, Messrs. Jas. Hennessy and Co., the well-known brandy distillers of Cognac, being the prosecutors. They applied for an injunction to restrain a trader from selling brandy as their "Three Star" brandy, which was not their brand at all. Evidence was called for the plaintiffs to show that a spirit was sold to a customer who asked for Hennessy's "Three Star" brandy, which was not Hennessy's "Three Star" brandy, but was of a totally different kind. A number of witnesses were called for the defence to contradict the evidence, but the Vice-Chancellor, in giving judgment, said that he felt no doubt that the brandy had been sold as Hennessy's "Three Star" brandy, and granted an injunction, with costs. This substitution has become so common of late in various parts of the United Kingdom that the successful result of an action such as this will, we hope, do much to put a stop to such trading in the public interest, and it affords us pleasure to record this result and to congratulate Messrs. Hennessy thereon. The profession, as well as the public, is interested in a question of this nature, brandy being one of its sheet anchors in certain cases, and the substitution of an inferior article is in the case of a patient as dangerous as the substitution of one drug for another in a prescription.

### A Surgeon's Fees Reduced.

In an action tried at the Nottingham County Court last week Mr. Elder, surgeon to the Nottingham Infirmary, sued a head coachman for £28 5s. for fees in connection with professional services rendered to the

wife of the defendant. It appears that the defendant's wife was suffering from acute peritonitis, for which an operation was deemed necessary, and with that object in view she was taken to Mr. Elder's private hospital, where she died three weeks later. The defendant pleaded that he had no idea that his wife was going to be removed to the private hospital, and offered £18 in settlement. The judge left it to the jury to say what amount would be fair and reasonable, and they put it at nine guineas, for which judgment was given.

### Change of Hospital Name.

At a recent General Court of Governors of the North London Hospital for Consumption and Diseases of the Chest, it was proposed to alter the name of the institution to "The Mount Vernon Hospital for Consumption and Diseases of the Chest, Hampstead and Northwood," and finally it was arranged that in future, in order to prevent any confusion with University College Hospital, or any others bearing the name of North London, that it be called "The Mount Vernon Hospital for Consumption." The hospital is situate at Hampstead, the new sanatoria are at Northwood, and the central out-patients' department is at Fitzroy Square. This hospital, it will be remembered, recently received £100,000 from an anonymous donor, and it is well that in case like gifts are yet to come, that there should arise no legal difficulties regarding the name of the institution.

### The Peculiar People Again.

THE parents of a child, age 4, who had died of diphtheria in the absence of medical treatment, were committed for trial last week by the coroner for Southend.

### Vital Statistics.

THE deaths registered in the week ending December 7th in 37 large towns of the United Kingdom corresponded to an annual rate of 19.7 per 1,000 of their aggregate population, which is estimated at 11,468,028 persons in the middle of this year:—

Belfast 19, Birkenhead 18, Birmingham 21, Blackburn 28, Bolton 19, Bradford 15, Brighton 19, Bristol 16, Burnley 19, Cardiff 19, Croydon 18, Derby 14, Dublin 20, Edinburgh 19, Glasgow 21, Gateshead 16, Halifax 15, Huddersfield 15, Hull 17, Leeds 19, Leicester 15, Liverpool 22, London 19, Manchester 23, Newcastle-on-Tyne 17, Norwich 29, Nottingham 20, Oldham 23, Plymouth 17, Portsmouth 14, Preston 18, Salford 21, Sheffield 19, Sunderland 17, Swansea 20, West Ham 19, Wolverhampton 19. The highest annual death-rates per 1,000 living, as measured by last week's mortality, were:—From measles, 1.0 in Sheffield, 1.6 in Manchester, 3.0 in Oldham, 8.5 in Halifax, 6.5 in Blackburn, and 7.0 in Norwich; from scarlet fever, 1.2 in Birmingham; and from fever, 1.0 in Plymouth. In none of the large towns did the death-rate from whooping-cough reach 1.0 per 1,000. The 80 deaths from diphtheria included 36 in London, 5 in Liverpool, 4 in Sheffield, 4 in Glasgow, 4 in Belfast, 3 in West Ham, and 3 in Bristol. Sixteen deaths from small-pox were registered in London, but not one in any of the other large towns.

### University of London.—Examination for Honours.

THE following is an official list of candidates who were successful at the recent M.B. Examination.—Medicine.—First Class: Alfred Ernest Jones (Gold Medal), Henry Crewe Keates, John Henry Sheldon Harold Weightman Sinclair, Chas. J. Thomas, B.Sc. (Scholarship and Gold Medal). Second Class: Carey Franklin Coombs, Myer Coplans, Robert Kelsall, Albert Edward Thomas. Third Class: Ernest Gilbert Bark, William Henry Bowen, John Charlton Briscoe, Ellen Mary Sharp, James Ernest Stratton, George Ernest Waugh.

Obstetric Medicine.—First Class: Alfred Ernest Jones (Scholarship and Gold Medal), John Henry Sheldon, Charles James Thomas, B.Sc. (Gold Medal), Ernest Eric Young. Second Class: Olive Claydon, Carey Franklin Coombs, Ellen Mary Sharp, Harold Weightman Sinclair, William Henry Wynn, B.Sc. Third Class: Arthur Edmunds, B.Sc., Robert Kelsall, John Ford Northcott.

## Notices to Correspondents, Short Letters, &c.

☞ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

### ELECTION OF DIRECT REPRESENTATIVE FOR SCOTLAND.

DR. BRUCE begs to thank the Scottish registered medical practitioners, through the columns of THE MEDICAL PRESS AND CIRCULAR, to the number of 975, who, by their votes, placed him at the top of the poll at the late election. Especially he wishes to express his most grateful thanks to the large number of those who have taken the trouble to personally congratulate him on his victory. Now that the fight is over he assures the constituency generally of his desire to give his utmost energies towards advancing their interests, in so far as it may be in his power to do so, during his term of office.

QUEERENS.—Cocoa is, or should be, a paste or powder of the nut, without addition of any kind. When sugar, starch, or other farinaceous substance and flavouring matters are mixed with it the mixture is known as chocolate. To sell chocolate as cocoa is therefore a fraud on the customer.

M. S. P.—There are plenty of institutions where the lady could be received, but under the circumstances and in view of her social position it would perhaps be more conducive to her happiness if she were placed with a medical practitioner as resident patient.

### A NICE POINT.

AN inspector under the Sale of Food and Drugs Act entered a London chemist's shop the other day and asked for four ounces of aconite liniment. "I cannot supply you," said the chemist. "Why not?" queried Mr. Inspector. "Because I do not know you, and under the Pharmacy Act I am liable to a penalty if I sell a preparation of aconite to anyone unknown to me." "Well, I am the inspector for this borough under the Sale of Food and Drugs Act, and that Act says you are liable to a penalty if you refuse to supply me." The chemist was loyal to his own Act, and the inspector retired aconiteless. But it would be interesting to learn which law has the first claim to allegiance.—*Chemist and Druggist.*

MR. FISK.—We have complied with your suggestion.

A SUBSCRIBER.—(1) You cannot compel them to make the room habitable. Try persuasion—you have a good case to place before reasonable men. To leave without permission would be to vacate the appointment. (2) You were neither requisitioned by the relieving officer nor appointed locum tenens by the guardians. You were simply acting as a friend. Under the circumstances courtesy requires that the official named should waive his claim to his extreme legal rights.

### VENTILATING COWLS.

MR. ROBERT BOYLE, of "Ventilation" fame, has effectually disposed of the claim of the Sanitary Institute to be regarded as an authority on ventilation by means of cowls. The Institute appears to have issued a report of trials made with various cowls, and to have awarded high commendation to three, which were considered by practical experts both out of date and defective, the first award being to a patent held by the Institute itself. If this may be taken as a fair sample of the work accomplished in this direction we would advise the Institute to stick to the departments and the work originally designed for it by its founder, the late Dr. Parkes.

## Meetings of the Societies, College Lectures, &c.

### LONDON.

WEDNESDAY, DEC. 18TH.

ROYAL MICROSCOPICAL SOCIETY (20, Hanover Square, W.).—7.30 p.m. Mr F. W. W. Baker: Exhibition on Development and Structure of Eyes (illustrated by micro-slides).

BRITISH BALNEOLOGICAL AND CLIMATOLOGICAL SOCIETY (20, Hanover Square, W.).—8.30 p.m. Adjoined General Meeting. 8.45 p.m. Ordinary Meeting. Paper:—Dr. Clippingdale: The Clay and Gravel Soils of London and the Relative Advantages of Dwelling on either.

THURSDAY, DEC. 19TH.

HARVEIAN SOCIETY OF LONDON (Stafford Rooms, Titchborne Street, Edgware Road, W.).—8.30 p.m. Clinical Evening. Cases:—Mr. F. Jaffrey: (1) Trephining for Doubtful Cerebral Mischiefs; (2) Diffuse Craniotabes. Dr. E. Cautley: Infantile Scurvy simulating Acute Epiphysitis. &c.

### DUBLIN.

THURSDAY, DEC. 19TH.

Dublin University Biological Association, Front Hall, Trinity College.—8.15 p.m.

FRIDAY, DEC. 20TH.

Royal Academy of Medicine in Ireland. Section of Obstetrics-College of Physicians.—8.30 p.m. Paper:—Dr. Horne: Notes on a Case of Cesarean Section. Specimens:—Dr. Alfred Smith: (1) Large Fibro-cystic Tumour with extensive Adhesions; (2) Double Pyosalpinx (two specimens); (3) Ovarian Abscess. Dr. Hastings Tweedy: Two Ovarian Cystomata.

## Appointments.

- BENNETT, WILLIAM B., M.R.C.S.Eng., L.R.C.P., Honorary Surgeon to the St. George's Hospital for Diseases of the Skin, Liverpool.
- BERRSFORD, EDWIN H., M.R.C.S., L.R.C.S.Lond., Medical Superintendent of the New Metropolitan Asylum, Tooting Bec.
- BEVAN, ARTHUR, M.B.Lond., House Physician to the Hospital for Sick Children, Great Ormond Street, London.
- CLAYTON, JOHN CECIL, L.R.C.P.Lond., M.R.C.S.Eng., House Surgeon to the Bristol Eye Infirmary.
- COLLINS, E. TREACHER, F.R.C.S., Visiting Ophthalmic Surgeon to the Metropolitan Asylums Board Ophthalmia Isolation Schools at Brentwood and Swanley.
- CUTBERTSON, J. O., M.B., B.Ch.Oxon., Senior House Surgeon, Radcliffe Infirmary, Oxford.
- DALY, JOSEPH P., M.D., M.Ch.R.U.I., Certifying Surgeon under the Factory Acts for the Monasterevan District of the County of Kildare.
- DARLEY, A. R., M.D.Dub., Medical Officer of Health for Daventry.
- HALAHAN, ROBERT, M.B., B.Ch.Dub.Univ., House Surgeon to Stevens' Hospital, Dublin.
- HARDENBERG, E. J. F., M.R.C.S.Eng., L.R.C.P., Junior Resident Medical Officer to the North-west London Hospital.
- HUNTER, WILLIAM, M.B., C.M.Aberd., Government Bacteriologist to the Colony of Hong Kong.
- MEACHEM, G. NORMAN, M.B., B.S.Lond., M.R.C.P. Edin., Honorary Physician to the St. Pancras and Northern Dispensary.
- MUSCHAMP, B., L.R.C.P. Edin., L.R.C.S. Edin., Medical Officer of Health for the Yeading Urban District Council.

## Vacancies.

- Birmingham General Dispensary.—Resident Surgeon. Salary £150 per annum (with an allowance of £30 per annum for cab-hire), and furnished rooms, fire, lights, and attendance. Applications to Ernest W. Forrest, Secretary.
- Glasgow Royal Infirmary.—Superintendent. Salary £500 per annum, with board, house free of taxes, coals and light. Age not to exceed forty-five. Full particulars of Henry Lamond, Secretary.
- Mercer's Hospital.—Resident Medical Officer. Applications, with testimonials, to the Registrar, John Robinson. (See Advt.)
- Middlesex Hospital.—Assistant Physician, honorary. Applications to F. Clare Melhado, Secretary-Superintendent.
- Royal Portsmouth, Portsea, and Gosport Hospital.—Assistant House Surgeon. Remuneration at the rate of £50 per annum, with board and residence. Applications to J. A. Byrley, Secretary.
- Royal Surrey County Hospital, Guildford.—House Surgeon. Salary £100; board, residence, and laundry found. Applications to the Hon. Secretary at the Hospital.
- School Board for London.—Two Oculists (of either sex) for testing the eyesight of children in the Senior Departments of the Schools. Salary 100 guineas. The appointment will be temporary, for one year. Forms of application may be obtained at the offices of the Board, Victoria Embankment, W.C.
- South Devon and East Cornwall Hospital, Plymouth.—House Surgeon. Salary £100, with board and residence. Applications to Hemsley H. Shanks, R.N., Hon. Secretary.
- Waterford District Asylum.—Assistant Medical Officer. Salary £100 per annum, with board, washing and attendance. Applications to the Resident Medical Superintendent. (See Advt.)

## Births.

- GRIFFITHS.—On Dec. 16th, at 5, Kensington Square, London, the wife of Herbert T. Griffiths, M.D., of a daughter.
- LAST.—On Dec. 11th, at York Villa, Alumhurst Road, Bournemouth, the wife of T. Clifford Last, M.R.C.S., L.R.C.P., of a son.

## Marriages.

- ATKEY—MENZIES.—On Dec. 14th, at Holy Trinity Church, Hyde, Percy J. Atkey, M.R.C.S., L.R.C.P., D.P.H., of Southampton, to Barbara only daughter of the late Capt. William Menzies, R.N., and Mrs. Menzies, Hyde.
- BOWEN-JONES—EVANS.—On Dec. 12th, at St. Catherine's Church, Neath, South Wales, Lloyd Bowen-Jones, D.P.H., Medical Officer of Health for Carmarthen, to Clara, third daughter of the late Edward Evans, of Eaglesbush, Neath.
- FOSTER DALLAS.—On Dec. 12th, at Christ Church, Brockham, M. Bernard Foster, M.R.C.S.Eng., L.R.C.P., D.P.H.Lond., of Buckeridge, Herts, younger son of Michael E. Foster, of Brockham, Surrey, to Gertrude Mary, elder daughter of Seymour Dallas, J.P., of Kimberley, South Africa.
- STAHLKNECHT—GARDNER.—On Dec. 12th, at the parish church, West Kirby, Cheshire, Bernard Stahlknecht, M.B., Ch.B., of St. Harwood, Lancs., to Ethel Cleland, only daughter of R. B. Gardner, of West Kirby.
- TAUNTON—SMITH.—On Dec. 12th, at St. Peter's Church, Hengoed, John Godfrey Cresswell Taunton, M.R.C.S., L.R.C.P., of Old Brompton, Chatham, son of the Rev. C. W. S. Taunton, of Lostwithiel, to Edna Harriet, eldest daughter of Mr. and Mrs. Edwin Smith, of Aldington, Evesham.

## Deaths.

- GITTEMS.—On Dec. 12th, at 102, Claude Road, Upton Park, Essex, Emma E. Gittens, widow of the late Thomas Joshua Gittens, M.R.C.S.E.
- TAYLOR.—On Dec. 14, at Wargrave House, Berks, Bess Ann Taylor, of Fortlethen, widow of James Taylor, F.R.C.S., of Wargrave, aged 73 years.

# The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXXIII.

WEDNESDAY, DECEMBER 25, 1901.

No. 26.

## Original Communications.

### A DEMONSTRATION OF CHANGES OCCURRING IN UTERI IN WHICH FIBROMYOMATA ARE PRESENT. (a)

By E. STANMORE BISHOP, F.R.C.S. Eng.,

President of the Manchester Clinical Society; Hon. Surgeon to Ancoats Hospital.

MR. PRESIDENT AND GENTLEMEN.—It was inevitable that during the evolution of such an operation as hysterectomy for fibromyoma our attention as gynecologists should be directed more especially to the various methods proposed for carrying out that proceeding, and that, during the process of placing that upon a satisfactory basis, many minor points in connection with the subject should become clear to us which before were obscure, the full consideration of others should be postponed, and some should lose the importance which previously they appeared to possess.

Among those which, perhaps, many will feel inclined to consider as belonging to the last category is the behaviour of the uterine endometrium in presence of this neoplasm. If hysterectomy, more or less complete, be accepted as the most satisfactory solution in those cases in which operative interference is required, the consideration of what may or may not be the particular effect upon that membrane, removed as it is with the rest of the organ, of a growth in the subjacent tissues would almost appear to be a matter of indifference—indifference, I mean of course, to us as operators, not as pathologists.

There will always remain, however, a certain number of cases in which the only apparent tumour is a single one, projecting towards the central canal, or becoming more and more polypoid in its lumen. These cases are, moreover, such as in the opinion of many do not even yet justify total ablation of the uterus whilst at the same time their symptoms—especially the one most pressingly attracting notice, that of great, frequently recurring, and increasingly exhausting hæmorrhage—imperatively demand some remedy. In these cases it is possible that any observations, however imperfect, of the tissues most affected may throw some light upon the situation, induce others more competent to extend and amplify them, and may perhaps be of some service to those who have to decide how and in what manner they may best be dealt with. It is with that intention that I venture to bring before this Society to-night some photographs and specimens of the endometrium as I have found it in certain uteri, the subjects of this disease, which I have removed during the past few years.

It can scarcely be said that authorities are agreed as to the condition of the endometrium, which may be expected—for instance, in a case of submucous polypoid fibromyoma, in which the advisability of vaginal enucleation may become a question for discussion. To the practical gynecologist it then becomes of interest to know—

First: What is the condition of the endometrium over the tumour itself?

Second: What is its condition on the wall of the uterus opposing it?

Third: What is its state at the angle which the protruding mass makes at the point where it leaves the uterine wall? And

Fourth: What is its condition in the fundus and wall above the tumour which will be left behind when once the polypoid mass is removed?

It appears probable from the foregoing references that this will not be the same in every case, and I do not bring these specimens before you with any idea that their evidence will settle the question, but simply to add a small number to the many specimens which must be examined and recorded before any definite rule can be laid down.

In order not to weary you by endless and unnecessary repetitions, I have selected six microscopical slides, from a number taken from thirty different cases, which you will find under the microscopes, and these I have had reproduced for demonstration with the lantern, because they seem most typical of the changes found.

The first section I show you is taken from a uterus removed by me by vaginal hysterectomy some time since (a). The patient from whom it was taken was *æt.* 45, and had been married for twenty years. She had had two children, the eldest *æt.* 18, the youngest *æt.* 18, and she had had three miscarriages between the two for no very obvious reason. For the last twelve months she had only been free from hæmorrhage for fourteen days, and that about six months before operation. As may be imagined, she was extremely anæmic and very thin. She had two intramural fibroids, one tending to become subperitoneal and impacted in the pelvis behind the uterus, neither pressing particularly upon the endometrium, which, however, was thick, and almost purple in colour. The section is taken from the fundus near the opening of one Fallopian tube. As you will see, it shows distinctly hyperplasia of the glandular tissue, the gland cells well formed, and the glands themselves abundant, whilst the outermost layer of epithelium, where seen, is normally cylindrical and ciliated.

The next is taken from the fundus of a uterus of a woman, *æt.* 44, married thirteen years, with no children or miscarriages. Menstruation was regular and painless until twelve months before operation, on July 8th, 1901; used to last two to three days, but for the last twelve months has increased in amount and frequency. Period at time of observation lasts fourteen days. Six weeks before great pain lasting for three weeks continuously came on and appeared at intervals since. There had been no dysuria.

In this case two tumours existed in the posterior wall, and there had been pelvic peritonitis, resulting in a small collection of pus situated above the bladder and walled in by omentum. One of the masses was near to, but not pressing markedly upon, the internal wall, being still entirely intramural. The endometrium is

(a) Paper read and Demonstration given before the British Gynecological Society, December 12th, 1901.

(a) A similar section from the fundal extremity of the uterine canal of another uterus shows a similar condition.

here also thicker than normal, and not only so, but upon both walls, both that over and that opposed to the tumours, small glandular polypi were formed. The upper one, on the opposite wall, is first shown here, and the other can be seen in the succeeding slide lying a little below the point at which the innermost tumour most nearly approaches the lining membrane. The glands are well marked, the gland epithelia normal in size and intact, and the surface layer of epithelium is normally cylindrical and ciliated. It was impossible in both these specimens to use a sufficiently high power to show the last point, if we were to show at the same time the general features of the membrane itself. In the following, however, this becomes more important, and higher powers are therefore used.

The fourth specimen is taken from a uterus which contained two fibroid masses, one in the anterior, one in the posterior wall, both beginning to press upon the endometrium between. The patient from which this uterus was removed was a widow, *et.* 44. She had had no children nor miscarriages. She had always had a very free flow at the menstrual periods, but had had marked floodings during the past twelve months. There had been dysuria for the last two or three months. The section shows the glands in a compressed state and beginning to break up. The interglandular tissue is also disintegrating. Very few glands in the whole section are still normal. The fifth, sixth, seventh, eighth and ninth specimens are taken from cases in which the growths had become polypoid and projected markedly into the uterine canal and the condition of things in all but the next is greatly changed. A glance at the fifth is sufficient. It is taken from the angle made by the polypus with the wall from which it issues. The glandular structure here dips down between the growth and the wall, helping to accentuate the division between them, and is here fairly abundant.

But it is especially the next four slides to which I ask your attention. These show the condition of the endometrium over the tumour itself and over the opposed wall. It is, as you will see, almost non-existent, being only represented by a single line of epithelial cells, arranged vertically to the wall respectively over each, and seated directly upon the muscular tissue beneath. The connective tissue basis and the deeper-seated gland structures are gone. The endometrium is, as it were, spread out—opened out—over the advancing mass, and even the remaining cells have undergone a distinct change. In parts, where the pressure is not so great, they remain columnar; but lower down, where the force increases, they themselves become flattened and dwarfed until they approximate, although I cannot find that they ever absolutely reach, the squamous type; and this, it must be remembered, is *before* the growth reaches the vagina, and whilst it is still intra-uterine; of tubular formation at points where the pressure is not quite so complete there is an attempt. This and the next, show, I think, the final steps of the process remarkably well. In each you will notice that the epithelium rests directly upon muscular tissue. The interglandular substance is gone, but in this, ninth, there is still an attempt at, or remains of glandular formation, the pressure being as yet, not so great. The epithelia dip downwards, and in the centre, one complete gland tubule is cut across, the others being still open above but fairly deep. In No. 8 the line of epithelium is simply irregular, pressure being greater, whilst in Nos. 6 and 7, where pressure is greater still, it is entirely straightened out, and lies like a mere fringe on the surface of the tumour.

It is curious to note that precisely the same effects appear to be produced by the expansive force of the myoma itself, aided by the contraction of the uterine fibres behind upon the endometrium lying over its own surface, and upon that which faces it on the uterine wall opposite.

The evidence afforded by these sections, and many others similar, would appear to go some way towards justifying the following conclusions.

The presence of a fibromyomatous growth in the uterine tissue has an effect upon the endometrium lining that uterus.

In the early stages, and whilst still intramural, it tends to produce hyperplasia of the endometrium.

When becoming sufficiently submucous to exert some pressure upon the membrane, it produces compression of the glands, with subsequent disintegration both of them and of the interglandular substance.

When actually polypoid into the uterine canal, the endometrium over the actual mass and the opposing uterine wall is reduced to a single layer of cells, which becomes progressively thinner in proportion to the pressure exerted, and approximates the squamous type.

In many of these sections blood vessels and lymphatics are seen immediately below, or within a very short distance of, the protecting line of epithelium.

One practical result of such observations may be touched upon. The use of the curette for the purpose of checking hæmorrhage, so much advised in earlier times, would seem to be justified in those stages of the disease which occur before the tumour becomes polypoid. The endometrium is at first hypertrophied, then degenerate, and in either case might be removed with good effect, but the case is altered when an actual myomatous polypus is present. Then the endometrium over the tumour and opposed to it, being reduced to a mere line of epithelium, its removal can do no good, and may have very evil results, by laying open lymphatics, and permitting the entrance of micro-organisms, thus producing necrosis of the tumour on the one hand and metritis on the other, and a glance at these slides will demonstrate how easily this may be done.

But examination of these sections appears to me to be of interest from quite another point of view. The question of the *etiology* of fibromyomatous tumours may just now, to use the phraseology of the politician, be looked upon as a "burning" one. All kinds of theories with regard to it have been advanced by various writers, all of which are based upon observations of specimens of this kind. Some see in them the results of late development of embryonic structures; that, of course, means development of remnants of embryonic structures belonging to the subject's own person.

The view, however, which appears to have received the most general acceptance of late years, and which seems to furnish the key to much that is perplexing and difficult to understand in our experience of these growths, is that which ascribes the starting point of uterine fibromyoma to the over-development of the outer walls of certain uterine arteries or arterioles. It is thus described by Pillet. "The endothelium," he says, "remains normal; the adventitia gives origin to a zone of embryonic cells which multiply and develop into rows of concentrically-placed smooth muscular fibres arranged around the vessel. The fibrous layers arise from the transformation of the most peripheral muscular layers which are furthest from the vessel, and which, therefore, do not receive sufficient nourishment to allow of their normal development. Klebs, Mealy, and Hyenue agree with this description of the initial stage. Kleinwächter, Roesger, and Gottschalk mainly differed as to the relative size of the arteries involved, the first attributing it to changes beginning in the smallest, Roesger to those which possess an adventitia, and Gottschalk to the larger arteries.

If this view is accepted many things become clear. Arteries already lie in a bed of connective tissue, which separates them from the muscular fibres around. As a portion of the vessel enlarges this will be more and more compressed until it would very well form a band of fibrous tissue around, answering to the capsule, which when divided permits of the ready disengagement of the tumour from its environment, a fact which we constantly note in enucleation of these masses. The low nutrition of fibromyomatous masses is easily understood if we consider that blood can only reach it in any quantity through its central channel, except for the fine vasa vasorum which still perforate it from without, and that the calibre of this central channel must be progressively encroached upon by its own growth. In one of the sections I propose to show you, this, I think, is well



illustrated. The whorled appearance of the fibres characteristic of these neoplasms is also what might have been expected. All uterine arteries are convoluted, to permit of the ready alteration necessary in gestation, and especially in parturition. The fibres of a growth originating in them must necessarily be convoluted also. Even the increased growth of these tumours during pregnancy, and their corresponding decrease during involution, is more easily comprehended if we look upon fibromyoma as essentially a disease of the uterine vessels themselves, and not of comparatively indifferent tissues. Lastly, the difference between the rapidly growing and soft tumours of the cervix, and the hard, more slowly enlarging tumours of the fundus may be explained by the freer and more direct supply of blood to the former through the lower branches of the uterine artery.

It must, however, be admitted that this view by no means meets with unqualified acceptance. Moller (a) in 1899, after examining a large number of the minute myomata found in the capsule of larger growths, disputes the conclusions of Boesger and Gottschalk, and appears to consider the question disposed of since he has demonstrated the entrance of more than one vessel into these masses. I cannot see, however, after a careful examination of the drawings which illustrate his treatise, that these are necessarily any other than *vasa vasorum*, and some of his facts, as for instance that all the smallest tumours are entirely composed of muscular tissue, rather tell in favour of the theory we are discussing than against it.

But most observers, like himself, appear to have directed their attention entirely to the tumours already formed. I beg to suggest that more information as to the truth or otherwise of this theory especially might be anticipated from a study of the *uterus* from which they have been taken. It is common experience that any *uterus* in which a fibromyoma is found is likely to contain others more or less developed; that if it apparently only contains one, and that is removed, sooner or later another will be formed.

One of the cases from which the last sections shown were taken is a good illustration of this. The woman originally came to Ancoats Hospital in February, 1896, with a well marked single intramural fibromyoma, in the anterior wall, which was treated by vaginal myomectomy. She recovered, but returned in June of the present year with another single, but this time polypoid, growth of the same nature—i.e., five years after; but every gynaecologist has met with similar specimens. Now, if this theory be indeed true, it is only necessary to go a step further back; and it will be natural to suspect that in such a *uterus*, even if no other palpable or visible masses can be detected, at least we ought, under the microscope, to find arteries deviating in some way from the normal; that here or there we should find a section of an artery in which hypertrophy of the median layer is commencing; and acting upon that idea, I commenced a search through these slides for such an appearance. The results I wish to lay before you. It is for the Fellows of this society to say whether the slides I show, the originals of which will be found under the microscopes on the table, assist at all in arriving at some judgment as to the trustworthiness of Pilliet's theory. Under the microscopes, indeed, I think you will find nearly all the stages from slight to great media hypertrophy, for when you begin to search for them, it is astonishing how many you can find in some *uteri*—not in all. Some of these were found too late for reproduction as lantern slides, but enough are shown, I think, to render the point clear. At the time these lantern slides of arteries were made I was unable to get photographs direct; they are reproduced from drawings by a very clever artist, Miss Bradbury. I would merely add that I have not been able in them to see any zone of embryonic cells, with the powers Zeiss  $\frac{1}{3}$ th—and 1-12th oil immersion—I have used, but that there is in some of these sections marked hypertrophy of the arterial media will,

I think be admitted, whatever bearing such appearances may be deemed to have upon the question of etiology.

In the first slide I have had photographed a normal artery with normal walls taken from one of these *uteri*, for purposes of comparison. All these slides are taken with the same powers of the microscope. Zeiss E. objective, No. 1 ocular, tube not drawn out or, in other words, magnified 280 diameters.

In the second slide I think it will be admitted that, in proportion to the diameter of the artery, the media is decidedly thicker. The ring of intima, with its somewhat nodular nuclei, is well seen.

In the third this thickening is shown to be irregular. On one side the wall is much more hypertrophied than on the other. The intima, marked by its nuclei, can be seen on the sides of its lumen.

In the fourth the hypertrophied wall has almost obliterated the lumen of the artery, but the circular ring of nuclei from the intima is still visible.

In the fifth, a group of arteries are seen, still containing some blood corpuscles. The gradual thickening of the media is very well shown. From the small, almost normal, artery below and on the left, to the greatly and very irregularly enlarged artery on the right, the enlargement being entirely in the muscular wall. In each the ring of nuclei showing the presence of the intima is to be noted.

In the sixth, a further stage of medial hypertrophy is shown, and this and the next, are, I think, particularly to be noted, in that the section in both appears to have passed squarely across the artery, so that there can be no question of the appearance as having been due to any obliquity in the way in which the vessel was cut. In an oblique section the thickness would be accentuated at each end of the artery, whereas all portions of the arterial wall show an equal increase in width.

In the seventh an artery with still thicker muscular wall is to be seen. The intima bridges over the irregular enlargement, and on the right where this is seen, a distinct thickening inwards encroaching on the lumen is worthy observation. The muscular fibres at each end appear to be blending with the uterine fibres around.

Whilst in the eighth, and last, a curiously tortuous artery, which has evidently been cut somewhat longitudinally, is shown: the intima well marked, following all its sinuosities, the lumen still containing some corpuscles; the media very irregularly thickened and at points almost obliterating the lumen; the adventitia, or cellular tissue bed in which the artery lies, isolating it from the surrounding tissues.

It is curious that Gottschalk has declared that myomata are developed from a strongly twisted section of one of the larger arteries, and this particular section would seem to give some colour to the statement; though I think the other sections do not. However that may be, the general result of my search would appear to show that the arteries in a *uterus* which has been the site of a fibromyomatous neoplasm do show certain changes in their structure differing from the normal; that those changes consist mainly of a more or less irregular hypertrophy of the muscular coat, and that it is perfectly possible that such hypertrophy carried to a sufficient extent might produce the masses or neoplasms which are known as fibromyomatous tumours.

If this is true it will be apparent that it has a very direct bearing upon practical questions: How far are we justified in retaining an organ in which this formation has once been demonstrated? Shall we entirely remove it, or shall we adopt the method so ably demonstrated and recommended here by Dr. Alexander, of Liverpool, or one of the many minor methods of a similar type? If we decide upon hysterectomy, shall it be the complete operation described by Mr. Christopher Martin, or the supra-vaginal amputation which finds so talented an advocate in Dr. Heywood Smith? All these are questions of so important and wide-reaching a character that I can only venture to suggest them to your minds. Without doubt very many more observations are required before

(a) Moller Studien zur Etiologie des Uterus Myoma, Berlin, 1899.

a definite answer can be given, and I can only hope that the few I have been able to bring before you may excite far more competent minds than mine to still further investigate the matter, so that our present doubts may be set at rest.

It only remains for me, gentlemen, to thank you for the patient attention you have given me, and to hope that I may have succeeded in exciting your interest in this, to me, fascinating question.

Mr. Targett said he had examined sections of many uterine fibroids, and thought there was abundant evidence of thickening of the muscular coat of the vessels and of their fibrous sheaths. After a time the new material became fibroid and almost devoid of nuclei. This degenerative change was very characteristic of uterine myomata, and enabled their structure to be easily distinguished from normal uterine tissue. As regarded the endometrium he had in some cases found hyperplasia especially affecting the stroma; while in others the endometrium had been thinned by distension, and its glandular follicles had become disarranged, or even obstructed at their mouths, causing retention of secretion and shed epithelium in their acini. He had never met with tubules lined with epithelium in the substance of a fibroid, and therefore did not think that these tumours commonly originated from congenital relics in the uterine walls, as stated by some observers.

## THE SURGERY OF THE SKULL AND ITS CONTENTS. (a)

By J. S. McARDLE, F.R.C.S.,  
Surgeon to St. Vincent's Hospital, Dublin.

As in the operative treatment of abdominal and thoracic affections aseptic, in contra-distinction to antiseptic, methods have led to great reduction of mortality, so too in dealing with the brain, its membranes, and osseous support a decided advance has been made.

In even modern practice we often see a contemptuous disregard for the method adopted in the treatment of compound fractures of the skull, and still if we examine the cases of death from such injuries we find that most of them die from septic meningitis. If in similar fractures of the long bones it is necessary to deal vigorously with parts that have been exposed to infection, it stands to reason that in dealing with fractures which open up the diploe, and at the same time expose the dura, the most vigorous precautions should be taken in the matter first of cleansing the wound, and second in the establishment of a free exit for the products of microbic activity should serious infection have occurred. If now we add to the fracture and infection an intracranial effusion of blood or serum so likely to favour septic complications, does it not become apparent that the more thorough and radical the surgical procedure adopted the more certain will be the result.

Again, when we come to deal with injuries of the skull in which the element of infection is absent, do we not often meet cases in which excessive intracranial tension has been allowed to continue so long that serious brain lesions arise. In these cases why should we not work on the same lines as in the surgical treatment of over-tension elsewhere.

Again, in cases of febrile affections how many patients are allowed to pass into a state of coma from intracranial pressure long after the general tissues of the body have satisfactorily dealt with the microbes. Why in those cases should we not relieve the brain and spinal cord of products of microbic action. Again, in syphilitic, alcoholic and

other diseases which cause intracranial tension, why should we depend on medicinal derivation when the brain can be relieved at one stroke by the method which I advocate. The cases which I desire to bring before you have convinced me that the department of surgery now under consideration has been overshadowed by the brilliant results obtained in other surgical fields.

There is one thing we should insist on in the treatment of most of these cases—that is, the drainage should be thorough. Many a case that seems hopeless on the table, when so placed that cranial drainage is perfect, advances so rapidly towards recovery that one is astonished at the result. That asepsis is essential in the treatment of all injuries of the head anyone having experience of brain surgery must recognise, but it is well to remember that the brain is not tolerant of such fluids as carbolic acid and corrosive sublimate.

CASE I.—W. G., *æt.* 40, was admitted to St. Vincent's Hospital, on December 3rd, 1890, when the following history was elicited:—On Saturday, November 15th, he fell into the hold of a vessel, striking the left side of his head; he was removed in an unconscious condition to Sir Patrick Dun's Hospital, where a wound over the left eye was dressed. In a few hours consciousness returned, and he went home the same evening. The next day being Sunday, he rested, and on Monday resumed his work as coal-porter. All went well until Monday, December 1st, when he felt disinclined for work, had some sickness of stomach, and noticed his left hand weak. During the evening of that day he experienced severe pain in the top of his head, and the weakness of the arm increased. On Tuesday, sixteen days after the accident, he found the left leg becoming powerless, and the following day he came under my care. He then had partial paralysis of left arm and leg. There was a scar over the left eye; pulse, 54; temperature, 96.5°; pupils normal, and respond to light. Although he seemed stupid he answered quickly and accurately. I had his head shaved, and the most careful examination did not disclose any external evidence of injury on the right side. It was evident from the slow pulse and subnormal temperature, as well as the paralysis, that compression of the brain was present. I scraped away. After thoroughly irrigating the parts with boracic solution, I sutured the dura mater, laid a medium-sized drainage tube across the wound, passing deep sutures to fix the scalp flap. For some time there was a copious serous oozing, which necessitated frequent change of the dressings, but late in the evening drainage seemed complete and at 3 a.m. on the 6th consciousness returned, the patient raising at the same time the arm which had been paralysed, and saying to the nurse in charge, "Begor, I've the use of myself, ma'am."

From this time recovery was uninterrupted, and on the 14th—that is, eight days after operation—the patient was about, the wound being soundly healed.

CASE II.—R. C., *æt.* 16, was brought to me by Dr. Fulham, of Swords, with the following history. He had been kicked by a horse in the centre of the forehead. He was found unconscious in a stable, and carried to bed, the wound dressed, and stitches inserted, all this time the patient being unconscious. Consciousness returned soon after, but only for a short time, in the stage of secondary unconsciousness he was brought to St. Vincent's Hospital, where I found him in the following condition: Unconsciousness was complete, there was a marked fulness above the root of the nose, fluctuating, and having a sharp outline corresponding to where the central portion of the frontal bone was driven into the brain. His breathing was laboured, his pulsation slow and heavy

(a) Paper read before the Royal Academy of Medicine, Dublin, Dec. 6th, 1901.

As unconsciousness was not continuous I believed the fractured bones were loose, not exerting much pressure, and that the brain trouble was due to intracranial hæmorrhage I trephined over the meningeal artery and removed the disc of bone which I now exhibit showing that the artery had been turned by a sharp projection at the neighbourhood of the fracture under the bone, as well as beneath the dura, blood was effused, and to remove it it became necessary to take away the portions of the frontal bone which I now place before you. The large opening formed by this operation enabled me to thoroughly relieve the brain pressure. The cost of this case is such that the lad who had been of a delightful temperament before, became, for some months, a veritable demon in a short time. In time this unfortunate mental condition disappeared, and he is now as you see him to-night—his old self again.

CASE III.—C. H., æt. 30, sustained a fall while riding at Roscommon races. I saw him two days later in the Roscommon Infirmary; he was then perfectly unconscious and thoroughly paralysed in the left side and partly so in the right. Most of the reflexes were present, but he had lost control of the bladder. His condition improved somewhat in the following weeks, and he was brought to St. Vincent's Hospital on August 6th in the following condition:—He was half conscious, had paralysis of speech, which after a time became somewhat clearer. He had contractions of flexors of left arm and leg, but no voluntary control of either. On October 19th I opened the skull on the right side over the hard centre. The bone was very dense and over a quarter of an inch thick. The dura was much thickened and protruded without pulsation. Incision of dura was followed by discharge of much sero-sanguineous fluid, and then brain pulsation returned.

For some days there was a free flow of this fluid, after which consciousness returned, and gradually he gained power over the leg, and later the arm became useful. Since that time recovery has been rapid and permanent.

CASE IV.—L. G., æt. 11, fell while playing with his brothers, his head coming in contact with some metal steps in the garden. Immediately after the fall, and when he was apparently perfectly well, he came in to dinner. During dinner he became drowsy, and later on he was obliged to be put to bed, when vomiting set in. For some weeks he was kept under treatment, and gradually he became well except for epileptic seizures which occurred every two or three days. These fits became more violent, the frequency remaining the same until he was brought under my care two years later. His parents were hopeless, and only submitted him to surgical treatment because anything would be better than to have him grow up in the miserable condition in which he then was. At first when he came under observation it was impossible to determine the seat of brain lesion, general convulsions seemed to start without any premonitory symptom. On close observation it was found that the fit was ushered in by a deflection of the eyes to the right. After this all reflexes of muscles of the arms, specially those of the left, became marked. I opened the skull on the right side about the centre of the fissure of Rolando. When I reached the dura it bulged into the trephined wound. Incising it I gave exit to about two drachms of serous fluid, the removal of which started a characteristic convulsive seizure. I laid in a small drain and closed the wound. The lad is here to-night to prove how successful the procedure above mentioned has been.

CASE V.—E. M., æt. 13, was brought to me from Newcastle West with the following history: Some years before he had fallen from the top of a tier of boxes, striking his head against a wall in his descent.

Some time after he became stupid, and later epileptic seizures appeared, these increasing in frequency until he became a burden to himself and a nuisance to everybody near him, and the expression used when he was placed under my care shows how little was thought of his chance of ever becoming useful. When I spoke of the gravity of the operation which would be needed for his relief his father said, "Do what you like with him, death is better than to have him as he is." The only guide I had to the position of his brain, in which the lesion was present was a curious symptom connected with his visual senses. He explained to me that before an attack came on he saw a circle of light in front of him, then a black cloud came down and he knew no more. In this case I opened the skull so that I could reach the angular lobe. On reaching the dura, there was an absence of brain pulsation, but on opening it no fluid escaped. I passed MacEwen's cannula through the brain substance in three or four directions without result, but on passing it inwards and backwards towards the cuneate lobe there was a rush of blood-stained serum with an oily look on the surface. I did not deem it necessary to permanently drain the cavity from which this was expelled, and so I completely closed the scalp wound. This boy had a characteristic fit on removal to bed, and now, three years after the operation, the report is that he has never had the slightest trouble since.

CASE VI.—F. K., æt. 14, came under my care on January 6th, 1901. Until eight months before he was in perfect health and was intellectually all right. He then contracted a severe attack of measles, through which he passed with some difficulty, and after some weeks of unconsciousness, when his physical strength returned it was found that he had lost speech, and his right leg was somewhat powerless, and that his right arm was almost paralysed. Under judicious management the paralytic symptoms disappeared to some extent; his mental activity remained impaired, speech being practically absent. Believing that this was an instance of meningeal effusion, I opened the skull on the left side a little above the convolution of Broca, removing the disc of bone which I now exhibit. There was no pulsation. The dura bulged into the wound, and on examination of this a large amount of sero-sanguineous fluid escaped. There was a considerable amount of drainage during the next six days, after which day the wound healed. Three days after the operation he was able to repeat any word one happened to mention. Ten days later voluntary speech returned, and on February 1st last, then one month after operation, he left the hospital, rapidly improving both in muscular and mental development.

CASE VII.—F. K., æt. 21, while riding a bicycle in the Park collided with another cyclist, and was picked up unconscious and brought to Stevens' Hospital. Some wounds on his face were attended to, consciousness returned, and he was allowed to go home to the South Circular Road, walking part of the journey. During the night he became stupid, the next day he was unconscious, but by the judicious treatment of Dr. Patterson, of the Meath Hospital, consciousness gradually returned, and I saw him in consultation with that gentleman on June 26th; he then had complete paralysis of the right arm and leg, slight impediment of speech, and internal strabismus. The diagnosis I made was intracranial hæmorrhage, with secondary effusion, and as the boy was rapidly disimproving I ordered him to hospital, and that night opened his skull in the position shown in the accompanying photograph, removing the clot which I now exhibit. This clot extended well under the base of the skull and the greater part of it was removed by a flat scoop and flushed with a thin tube. The boy left the hospital

on July 20th, and some weeks later he won a three-mile bicycle race.

## EHRlich'S THEORY OF HÆMATIC ANTIDOTES.

By PROFESSOR GRÜBER,  
Of Vienna.

THE lecturer believes that in all living protoplasm there is a central germ-structure which, chemically expressed, might be designated in its constitutional formula as a lateral union of the atoms of which this very complex structure is built up. These connecting links hold the molecules, which may contain a number of such atoms, together constituting what Ehrlich terms "haptophose" groups. These molecules consist of nutritive substances as well as toxic bodies and other derivatives of albumen. The susceptibility of one cell towards another, according to this theory, depends upon the dose of toxin in the "haptophose group." When the cell contains an excess thereof it is considered immunised by the added toxin, which may have produced a new "haptophose" leaving the organ's cell functionally as healthy as before the excess was produced. This excessive production of the "haptophose groups" may soon act as unnecessary ballast in the circulation, and entirely destroy the "toxophose group" with its prejudicial effect on the organism. The lecturer remarked that this was a hypothetical assumption with few facts to support it, but he confessed that the whole subject was an excellent mental exercise from which many hypotheses might be evolved with a certain substratum of fact in all of them.

Ehrlich believes the action of antitoxin on toxins to be purely of the nature of a chemical transposition of elements, and that this can be demonstrated according to the laws of multiples.

Concentration and temperature largely influence the results, although the toxins under any condition have a notable power of diffusion in gelatinous media. An excellent parallel of this action is to be found in the union between saponins and cholesterolin of the serum, in which a combination of the two bodies destroys the hæmolytic action of the saponins.

It must be borne in mind, however, that the combination of toxin and antitoxin does not abolish their individual existence after neutralisation, for, if the mixture be heated to 68° Cent., the poisons will be found to be as virulent as ever, even after a considerable period of time has elapsed. From this we may conclude that the substance is not in chemical combination, a fact which Behring pointed out long ago. Physiological and biological experiments have proved the fact, that although the two opposite substances are in combination, one of the poisons may produce its baneful effects after injection. We must conclude, therefore, that the whole subject of toxins is far too complex to be intelligently discussed in the present state of our knowledge.

There is another property of these toxins worthy of note, one too, to which Ehrlich himself draws attention in respect of diphtheria toxin. He affirms that the activity of this toxin diminishes on standing, or, in other words, he tells us that a larger dose of the toxin is required to produce the same results if it has been kept any length of time. He found that if the animal did not die a special latent period elapsed before the paralysis and œdema set in. This modified toxin he named toxone, and when the results were even less marked he employed the term toxoid. Ehrlich defines a toxoid as an organic poison in an organism that has missed the "toxophose group" while the haptophose group is still

persistent. He assures us that the diphtheria bacterium produces toxin and toxone, and that the latter may become converted into a toxoid. Here again strange inferences may be drawn from results. The anti-serum contains a definite number of units, which we will assume produces the toxone results, viz., œdema and paralysis, which may require forty units in the case of a dog. In the guinea-pig no toxone will be found, while the dog has both toxine and toxone. Again, two diphtheritic solutions may be used, equal volumes of which in grammes as units will kill a mouse, dog, pigeon, or horse. This proves that it is not the toxin molecule we have to deal with, but some other unknown influence of which we yet know nothing unless we assume that the species of the animal modifies our experiments. The opposite of this can be found in tetanus. Carmine reduces the virulence of tetanic saliva, since by gradually adding an aqueous solution water it loses its effect, or appeared to be transient in its action, and requiring no more antitoxin than the undestroyed poison. This certainly gives colour to a chemical formula similar to that of an alkali added to phosphoric acid, when the solution will not become alkaline until the last molecule of mono-phosphate is formed.

Another property of organic poisons is their dotency. One-fourth of a milligramme of bacterial toxin will kill a man, while it would take seventy of strychnine. Yet, notwithstanding this lethal effect, the dose, or even a larger dose, will go through a period of incubation, lasting in some cases for many weeks.

It seems also to be a recognised fact the more sensitive an animal is to the poison the more quickly the injection is washed out of the blood current.

If an animal be injected with tetanic toxin and antitoxin at the same time it will be found that the same quantity is required to neutralise, as in the laboratory experiment *in vitro*; if, however, seven or eight minutes elapse before injecting the anti-serum the quantity must be largely increased until fifteen minutes have passed, when the serum dose seems to become stationary. In susceptible animals the poison passes so rapidly out of the circulation that death ensues before the anti-serum can act upon it. Another interesting point in regard to tetanus is that the pigeon is very susceptible to the tetanic toxin, yet it is to be constantly found in its body, every organ being saturated with it, not excepting the brain and spinal cord, which it attacks violently. Ehrlich's explanation is that it is then in combination with other salts and thus remains inert in the body.

Wassermann has recently confirmed this opinion of Ehrlich's by examining the poison in the brains of guinea-pigs, which are also very susceptible to the poison, and he finds that when the toxin of tetanus is extracted from the brain it is devoid of toxicity, although that got from the other organs is by no means inert.

Behring, on the other hand, argued that the fact that an equal quantity of antitoxin, applied to a given quantity of toxin sufficient to produce paralysis, which, when mixed with an extract from the brain of a guinea-pig, could not be neutralised, this is a proof that the dead spinal cord is inactive till the cells are liberated. The poison can also be obtained from the brains of fowls, frogs, &c., which are also susceptible, by steeping the organ in a solution of common salt from which the tetanic virus can be isolated.

The incubation period is also somewhat against Ehrlich's theory of the poison being anchored in the ganglionic cell after bacterial growth since other substances such as colchicine, lead, and saponin, also have incubation periods, and yet

comport no haptophoso or toxophoso groups. The anchoring of these toxins must take place within a short period after administration; yet anti-sera are futile, while tetanus may take months to develop.

Again, the period of incubation varies according to the mode of administration, for subcutaneous and intravenous injections have much longer incubation periods than those applied to the intra-cerebral substance. Hanns Mayer has attempted another explanation by saying that the tetanus infection is local, affecting only the subjacent muscles. This explanation is quite unintelligible if the poison has entered the hæmatic circulation, which he goes on to prove that it does when he tells us that the axis-cylinders of the peripheral nerves are affected in the anterior horns of the cord.

The incubation is also short when the toxin is injected into the peripheral trunk of a large nerve, and as soon as the toxin has entered the axis-cylinder the anti-serum is inoperative.

Ehrlich attributes all the deaths to excessive production of the lateral combinations, or the haptophoso groups, which must be neutralised in the immunised animals by an 'anti-toxin secretion which in many animals must be immense, as the horse requires 100,000 anti-toxin units to be neutralised.

### Clinical Record.

#### A CASE OF DISSEMINATED SCLEROSIS. (a)

By Dr. J. MAGEE FINNY,  
Physician and Lecturer of Clinical Medicine at Sir P. Dun's  
Hospital, Dublin.

I AM enabled to show you a girl, æt. 22, with all the typical symptoms of this disease. Four years ago, at the age of 18, she became completely paralysed as to motion in arms and legs, with loss of control over the bladder and rectum, and with the formation of large bedsores on sacrum and nates. No cause could be found for her illness. She was a patient for fifteen months in co. Roscommon Hospital, under Dr. Blakeney, and left it so far recovered as to be in much the state she now presents. Having called attention to the rarity and peculiarity of this invasion of the disease, and commented on the variability of its course and progress, and the difficulties such variability produces in the diagnosis of disseminated sclerosis in its earlier stage, Dr. Finny pointed out the signs which were typically demonstrable on the patient, taking them *seriatim* and in the order of their prominence. 1. *Paraplegia*.—She is just able to stand and walk a few steps with help, but her gait is that of spastic paraplegia, and yet the legs present no spasms on handling or on flexion and extension. The ankle clonus and knee jerks are very exaggerated, and Babinski's sign of dorsal reflex in the right foot is present. The wrist and elbow reflexes are also exaggerated. Sensation is normal. 2. *The bladder and rectum* are fairly well under control, though there is often a delay in micturition, and if active aperients be taken, the bowels may move involuntarily. 3. *The tremors*.—These are absent as the patient lies in bed; both the head, shoulders, and crown jerk about in coarse tremors when an effort to perform any voluntary act is made—"intentional tremors," such as putting out the tongue, drinking out of a cup, &c. 4. *Speech*.—This is slow, deliberate, and syllabic—"scanning or staccato"—without slurring or fibrillary tremors of lips or tongue. 5. *The eyes*.—Mr. Swanzy's examination was to the effect that there was "nystagmus, V  $\frac{1}{2}$  in each eye. The field of vision much contracted, and the outer two-thirds of each optic disc were pale, pointing to partial atrophy." There was no optic neuritis, retinitis, or choked disc. 6. A notable complacency with her sad lot and a cheerful contentment with her surroundings, a feature laid stress on by Gowers as very characteristic of disseminated sclerosis, more commonly met with in females. Mention was then made of the following organic nervous diseases, which

more or less closely may simulate one or more of the salient features of disseminated sclerosis:—Paralysis agitans, general paralysis, mercurial tremors, syphilitic diseases, ataxic paraplegia, intracranial tumours, especially of the cerebellum, and transverse myelitis, and although the subject of diagnosis was not entered on or discussed, a warning was entered as to risk of confounding with it hysteria, not when all the typical symptoms are present, as in Dr. Finny's case, but when they were ill-defined and varied in extent, and gravity under the influence of time.

### Transactions of Societies.

#### BRITISH GYNÆCOLOGICAL SOCIETY.

MEETING HELD DEC. 12TH, 1901.

J. A. MANSELL MOULLIN, M.A., M.B.C.P., President,  
in the Chair.

#### CLINICAL CASES AND SPECIMENS.

DR. MACNAUGHTON-JONES showed the following specimens:—

1. **MALIGNANT MULTICULAR OVARIAN CYSTS COMPLICATING UTERINE MYOMATA.**—The patient was unmarried, æt. 48. Four months before consulting him she began to suffer in health, with abdominal pains and frequent bladder irritation. The periods had been fairly regular until a few months previous to his seeing her, when hæmorrhage set in, and continued intermittently until her operation. She was then greatly wasted in appearance, extremely anæmic, with a cardiac bruit. On examination fluid was detected in the peritoneal cavity, and an enlarged and myomatous uterus. An open diagnosis was made of ovarian tumour complicating myoma. She was operated upon on July 23rd, when the tumours shown were removed. She made an excellent recovery without any elevation of temperature. Two months after the operation she died of ascites and anasarca. At the operation a large quantity of ascitic fluid escaped. Two subperitoneal myomata were removed. The ovarian cystomata were the size of small melons. They had the appearance of multicellular colloid cystoma. The larger had evidently ruptured. Mr. Targett made a microscopical examination:—"Sections of the wall exhibit invasion of the capsule of the tumour with columnar-celled carcinoma, the cells of which are arranged in tubular form. Moreover, the capsule is perforated by the growth in places." The fact that the larger cyst had ruptured during life would explain the rapid infection of the peritoneum and the death from ascites.

2. **SARCOMA OF THE VAGINA.**—The patient was aged 44; married; last pregnancy twenty-two years since. In May, 1901, she suffered from a disagreeable discharge from the vagina. This became constant in June, and more diffuse and offensive. She stated that occasionally what she called "pieces of flesh about the size of a walnut" appeared with the discharge, and of late there had been severe bleeding on the slightest exertion. When he saw her she was very anæmic, with a sallow complexion. On making an examination he found the vagina filled with a soft, apparently carcinomatous, mass. This bled so profusely that it was not possible to proceed, and it was only under anæsthesia, at the operation, that he discovered that the cervix uteri was full of the growth which was quite concealed by it. It was then found that the mass was pedunculated and that it grew from the anterior vaginal wall behind the trigone of the bladder. Operation proved that it was quite free from the latter vices. The large pedicle was first secured with a rope exciser and secondly with a Billroth's clamp. The mass having been removed the cautery was applied to the stump. Then the subjacent base from which the tumour grew was ablated and the actual cautery applied to the raw surface. The wound was then covered by the vaginal mucous membrane. The most careful asepsis was maintained and the wound healed by primary union. Report on the growth by Mr. Targett: "This growth is a spindle-celled sarcoma of the vagina. The surface is ulcerated and covered with necrotic material.

(a) Case shown before the Medical Section, Royal Academy of Medicine, Ireland, Dec. 13th, 1901.

Among the spindle-cells there are a few larger poly-nuclear cells."

8. ADNEXAL TUMOURS CAUSING UNCONTROLLABLE VOMITING—SALPINGO-OOPHORECTOMY.—Patient, *æt.* 26. Married twelve months. In 1900 she suffered from severe metrorrhagia for four months. She consulted him for constant sickness in November, accompanied by pains in the back and iliac regions. On examination he found an adnexal swelling at the left side, difficult to disassociate from the uterus, which latter was enlarged. On December 6th the sickness was worse, and with frequent vomiting and constant nausea. On examination the adnexal swelling at the left side was found much larger and softer. At the operation the left ovary, about the size of an orange, was found to be cystic. This was removed. The right contained another growing cyst. This was resected. From the time of the operation all sickness and vomiting ceased, and she is now quite well. Examination of the cyst proved it to contain sanguineous fluid from intra-cystic hæmorrhage.

Dr. HRYWOOD SMITH questioned the propriety of the cautery in the second case over so large a surface.

Dr. MACNAUGHTON-JONES said there was no objection whatever; it was a delusion to suppose that a perfectly aseptic operation could not be conducted with the free use of the cautery. He had recently seen Professor Zweifel, of Leipzig, who was a strong advocate for the cautery, use it freely in a number of gynecological operations, abdominal and vaginal.

Mr. E. STANMORE BISHOP (of Manchester) gave a demonstration and read a paper on

CHANGES OCCURRING IN UTERI IN WHICH FIBROMYOMATA ARE PRESENT,

which will be found in another column.

Mr. J. H. TARGETT had examined sections of many uterine fibroids, and he thought that there was abundant evidence of thickening of the muscular coat of the vessels and of their fibrous sheaths. After a time the new material became fibroid and almost devoid of nuclei. This degenerative change was very characteristic of uterine myomata and enabled their structure to be easily distinguished from normal uterine tissue. As regarded the endometrium, he had in some cases found hyperplasia especially affecting the stroma, while in others the endometrium had been thinned by distension and its glandular follicles had become disarranged or even obstructed at their mouths, causing retention of secretion, and shed epithelium in their acini. He had never met with tubules lined with epithelium in the substance of a fibroid, and therefore did not think that these tumours commonly originated from congenital relics in the uterine walls, as stated by some observers.

Dr. MACNAUGHTON-JONES said that endometritic changes were among the commonest degenerations found in myomata—one point he wished to emphasise, and that Mr. Bishop's paper drew attention to, namely, the danger of curettage in some cases of myoma. The operation of "scraping" was so commonly resorted to that it was just as well to remember that in certain forms of myoma it was worse than useless, and some women dated all their worst symptoms from the operation of curettage. Hæmorrhage, for instance, which had been comparatively trifling before, increased.

Dr. STANMORE BISHOP replied. He hoped that Mr. Targett in future researches would record the changes observable in the vessels of the endometrium and the glandular structures. He agreed with the remarks as to the dangers of curettage in certain cases.

Dr. MACNAUGHTON-JONES then demonstrated several recent gynecological appliances, including a most useful flushing retractor employed by Professor Leopold for vaginal operations, and a new self-retaining trocar of Kœberle for ovariectomy. He described the Zweifel suture, and showed the gut used in his klinik, which is thus prepared. It is wound on a glass plate with ground edges, so as not to cut it. It is next placed in chromic solution for fifteen minutes (1 in 1000), and then washed in water. It is a second time for fifteen minutes placed in the chromic solution, and dried at a temperature of 80 degs. (Cent.) It is then made into rolls and subjected to 100 degs. (Cent.) The final

drying must be complete. It is then taken out of the chromic acid and placed in cumol for an hour and a half, at a temperature of 160 degs. (Cent.) It is now put into benzine of petroleum with a sterilised forceps, and the benzine is changed once (after half an hour), and fresh benzine put in. It is now placed in sterilised glasses, and is ready for use.

The new bronze aluminium wire, as employed by Professor Bumm, of Halle, he had used in several abdominal sections, and it made a clean and perfect continuous or interrupted skin suture, the result being exhibited in the photograph. Professors Krönig and Menge used a cotton thread permeated with collodion for the same purpose. The Zweifel suture was demonstrated, as also the advantages of the use of Kocher's forceps in hysterectomy, in lieu of either the clamp method of Doyen or Zweifel. Reference was made to a new mode of dressing in the abdominal toilet carried out at Professor Säger's Klinik by Dr. Kleinhaus. The first dressing was covered with the material "colactin," which hermetically closed the abdominal surface.

ROYAL ACADEMY OF MEDICINE, IRELAND.

MEDICAL SECTION.

MEETING HELD FRIDAY, DEC. 13TH, 1901.

In the absence of the President, Sir C. Nixon, the chair was taken by Dr. WALTER SMITH.

Dr. FINNY read notes of a case of "Disseminated Sclerosis" in a girl (patient shown) which will be found under "Clinical Records."

Dr. GEORGE PRACOCKE read a paper on  
HEMICHOREA AND PAROTITIS COMPLICATING A CASE OF  
DIABETES.

The patient, a man, *æt.* 64, was admitted to the Adelaide Hospital on April 29th, 1901, suffering from diabetes. He presented the usual symptoms, loss of flesh, great thirst, and polyuria. The quantity of urine passed in the twenty-four hours varied from three to five pints, and quantitative analysis gave 2.7 ozs. of sugar on May 2nd; somewhat less on subsequent occasions. He continued very drowsy throughout his illness; at times the condition almost approached coma, and he died on May 28th, just four weeks after admission. On May 4th he developed left-sided hemichorea, which resisted treatment with hyosine, bromides and chl. ral. Areenic in 10 min. doses was given, and 20 grs. of trional at night. Improvement rapidly followed, and all the chorea symptoms disappeared on May 13th. The value of trional in chorea has been alluded to in the *Medical Annual* for 1900, and also in the *British Medical Journal* for November 2nd, 1901. The writer had also used it with success in the case of a girl, *æt.* 11, who was admitted to the Adelaide Hospital in January, 1901. It was suggested that the cause of the chorea in the present case was the action of some poison due to the diabetes circulating in the blood and acting on the nerve cells controlling the motor apparatus. The second complication, parotitis, first made its appearance on May 11th. At first it gave rise to little trouble, but on May 16th there was some elevation of temperature and the parotid gland became painful and tender. The fever continued until the patient's death, but never reached a higher point than 101.6°. The cause of the parotitis was quite obscure, and though a similar condition has been described in a variety of diseases and injuries of the abdominal organs, so far its occurrence in the course of diabetes has not been recorded.

Dr. WALTER SMITH, Mr. H. G. CROLY, and Dr. PARSONS discussed the paper.

Dr. DAWSON read a paper on

"GLYCOSURIA AND INSANITY" (CLINICAL STUDY).

which we hope to publish in full in our next.

Cases of glycosuria associated with insanity were of two classes—those in which the insanity was secondary and those in which the glycosuria was secondary, the first being rare. He had had one case of the first class at Farnham House, that of a woman who had suffered for many years from polyuria and recurrent melancholia, with general debility, the melancholia being of the type

described as characteristic of diabetic insanity. She had been admitted for a severe attack, and, sugar being present in the urine, was put on diabetic diet. The sugar and the mental symptoms disappeared, and she was discharged recovered in about two months. The diet has since been persisted in, and she has remained unusually well for about a year. Two other cases were then briefly described which probably belonged to the second class. In one depression dated from an attack of influenza; in the other, the melancholia was a second attack, the first following an injury to the head. Both had glycosuria, for which they were treated, and recovered, so far as the acute attack was concerned. In four more cases glycosuria had been present on a few occasions only, and had not been treated, the forms of mental disease being respectively paranoia with depressing delusions, sub-acute mania with a tendency to stupor, acute mania with stupor and unpleasant delusions, and acute confusion. In all but one of the seven cases a prominent characteristic was mental discomfort, and, when it could be tried, there was high blood-pressure during the acute stage. Five had made good recoveries, and one was in a fair way to do so, the paranoia being, of course, incurable. In true diabetic insanity the mental symptoms were due to cerebral malnutrition. The glycosuria when merely symptomatic was probably purely alimentary, and dependent on a failure of sugar assimilation which had been observed to be especially frequent in melancholia. Glycosuria did not appear to be necessarily of bad prognostic import in insanity.

Dr. WALTER SMITH would like to ask Dr. Dawson whether glycosuria was more common among the insane than the sane. Savage had found it in not more than 3 per cent. in the patients at Bethlem Hospital; this differed from the experience of the Vienna physician, who found that 12 per cent. of the insane suffered from glycosuria. He would also like to know from Dr. Dawson if glycosuria gave rise to any special form of insanity. He was under the impression that it was associated more with melancholia than exaltation. When glycosuria does occur in the insane, is it characterised by any special symptom, such as slight polyuria?

Dr. LEPPER asked what is the relationship between glycosuria and insanity? Of the admissions under his care in Swift's Hospital 3 per cent. suffered from glycosuria. They presented none of the classic symptoms of diabetes, except the presence of sugar. The Hindoos suffer greatly, every family has lost some member through diabetes; on the other hand the phlegmatic Chinese escape—of 15,000 persons examined not one suffered from it.

Dr. HAYES also spoke.

Dr. DAWSON, in reply, stated that he looked on glycosuria as uncommon in the insane; these were the first cases he had. The more common forms were melancholia and senile dementia. In all his cases he found high blood pressure. Special senses seldom affected in diabetes mellitus.

Dr. J. J. BURGESS exhibited a specimen of unilateral fatty degeneration of the heart, taken from a man, *æt.* 35. The left ventricle was normal, but the walls of the right were almost wholly fatty tissue. Until the moment of death the man made no complaint. The pericardium was distended with blood. The ventricles were covered with lymph, which was readily peeled off, and had a fluffy appearance. The auricles were normal. The aorta was atheromatous.

Dr. J. J. BURGESS read notes of

#### AN UNCOMMON CASE OF SUDDEN DEATH:

The case I bring before you this evening is one of sudden death from what I take to be a combination of circumstances which are uncommon. The patient was a poorly-nourished man, *æt.* 35, a labourer out of employment. From the evidence at the inquest I learned he at least did not complain of being unwell until the fatal seizure came on. I presume that whilst seeking for employment he was noticed by some people to suddenly fall with his shoulder resting against a wall, and then drop to the ground. The people did what they could to revive him, but when the ambulance arrived he was so evidently

dead that they took him to the Morgue instead of one of the hospitals. The body was, I remarked before, not well nourished, but not emaciated; both lungs were emphysematous with a large amount of muco pus in the blanched system, but exhibited nowhere cicatrices nor consolidation. The pericardium was distended, on opening which somewhat over a pint of fluid blood and clots exuded, both ventricles especially. The surfaces of the right ventricle were covered by recent lymph, which at the time could be easily detected, and presented that fluffy appearance which you can see faintly in the specimen. Before removing the heart I searched assiduously for the source of the hæmorrhage but without result, nor could I find it afterwards. On opening the heart it will be noticed that the valves are in no way affected, the entire ante-wall of the right ventricle is principally composed of fat, there is almost a total absence of muscular fibre; this is very striking on comparing it with the left ventricle, which is fairly normal. Both coronary arteries are permeable. In the right ventricle was a clot formed at time of death. Both auricles present nothing abnormal. The aorta shows considerable evidence of atheroma. Although I have not been able to demonstrate the source of the hæmorrhage, I think the cause of death is obvious. During an attack of acute pericarditis, associated with a previously diseased heart, a bleeding occurring, was sufficient although small in amount to cause by its presence fatal paralysis. I find on consulting the literature on the subject that hæmo-pericardium is produced by two sets of causes, the most common being the rupture of the left ventricle of an aneurysm or of some vessel into its sac; the second in which during the course of pericarditis of cancerous or tuberculous origin a bloody serum is exuded into the sac, and a similar effusion also in some cases of scurvy and purpura. In my case there was no trace of malignant disease nor tuberculosis, but it owes its interest as one of acute pericarditis with the very uncommon complication of a true hæmorrhage, probably from capillary vessels which, although comparatively small, was sufficient on account of the diseased condition of the myocardium to cause sudden death.

Dr. FINNY doubted Dr. Burgess' statement that the change in the ventricle was due to fat. He suggested a new growth of some description as more probable. He was of opinion that a histological examination should be made of the heart before the case was published in the "Transactions."

The Section then adjourned.

#### EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

CLINICAL MEETING HELD DEC. 18TH, 1901.

Dr. ANDREW, Vice-President, in the Chair.

MR. C. W. CATHCART showed a patient after drainage of both pleural cavities for double empyema. The empyema followed pneumonia, and the only micro-organism present in the exudation was the pneumococcus. The left pleura was drained and the right aspirated simultaneously; as the right subsequently re-filled, a rib was resected about a week later. The patient, a lad, *æt.* 16 made an excellent recovery.

Dr. W. ALLAN JAMIESON showed a patient who had been under his care for many years on account of a patch of lupus on the chin, which had proved very intractable. This summer it had been subjected to the Finsen light treatment, and had apparently completely healed. He also showed a case of rodent ulcer, where the X-rays had been successfully employed.

Mr. ALEXANDER MILES showed (1) a woman who had been admitted to hospital suffering from severe gastric hæmorrhage. There was no previous history of ulcer. He opened the abdomen, and, finding an ulcer about the size of a five shilling piece near the pylorus—too large, therefore, to excise—performed posterior gastro-enterostomy. The symptoms caused by the loss of blood were combated by injection of saline solution into the peritoneal cavity and into the bowel, and the patient recovered completely. (2) A man who

was sent into hospital with the history of previous chronic partial obstruction of the bowel, which had assumed an acute form on the day of admission. The abdomen was generally tender, and visible peristaltic movements could be seen. As there was no clue to the site of the obstruction, the abdomen was opened in the middle line, when the peritoneum was found studded with yellow tuberculous nodules, while a fibrous adhesion constricted the lower bowel. This was divided, the abdomen was emptied of fluid, and closed. During the convalescence symptoms of pleurisy developed, and on the diagnosis of tubercle being confirmed by the examination of the exudate, the pleural sac was opened four weeks after the abdominal operation. Now, three years later, the patient enjoyed good health. (3) A case of excision of the rectum by Kraske's method. The stricture was about an inch and a half from the anus, and the tumour was adherent to the prostate. The patient had gained two stones in weight since the operation, and had partial control of the bowel.

Dr. W. G. SYM showed a case in which double excision of the lachrymal sac was performed. As it was necessary also to remove a cataract, and as the risks of extraction were greatly increased by affections of the lachrymal apparatus, he had had the conjunctival sac examined bacteriologically before touching the cataract. Finding that numerous pyogenic organisms were present he delayed for a month, using antiseptic lotions the while, and then, when the conjunctiva was aseptic, extracted the lens. In his experience, epiphora never followed removal of the lachrymal sac.

Mr. STILES showed (1) a boy after operation for recurrent tubercle and stricture following amputation of the penis for tuberculous disease of the glans. (2) Four cases of congenital wryneck, showing the results of treatment by the open operation. He had given up operating subcutaneously, because experience showed that mere division of the sterno-mastoid was insufficient, and it was necessary to expose the parts freely, and cut through any deeper structure which prevented the head being straightened. In the patients shown the divided sterno-mastoids had not reunited, but the movements of the head were not in any way impaired. Mr. Stiles regarded wryneck as a congenital deformity, and thought that the occurrence of hematoma of the sterno-mastoid was not to be looked upon as a cause of the condition, but rather as an effect, the abnormally short muscle being liable to injury at birth. Miculicz had stated that in wryneck there was chronic myositis of the muscle, and that it was not sufficient merely to divide it, but that the lower two-thirds should be excised. Mr. Stiles had not found that this proceeding was essential. All his cases showed the usual facial asymmetry, and this, he thought, supported the idea that wryneck was really due to some congenital abnormality. (3) A child, *æt.* 14 months, after operation for congenital malformation of the anus.

Mr. ALEXIS THOMSON showed a woman, *æt.* 52, on whom he had performed pylorotomy for cancer three and a half years ago. The tumour was attached to the pylorus, but there were no signs of pyloric obstruction, so that the only operation considered was pylorotomy—a gastro-enterostomy would not have given any relief. The interest of the case was the long period which had elapsed without recurrence, and now he hoped that the patient might be considered immune. As bearing on the prognosis of such cases he said that the tumour had proved to be a columnar-celled epithelioma—one of the less malignant, though unfortunately rarer types, of cancer. He had never seen a case of infiltrating scirrhous in which recurrence had been postponed for more than two years. Apart from the fact that this patient was obliged to take her food in small quantities at a time, she had no inconvenience whatever.

Mr. CAIRD showed a patient after operation for high shoulder, due to an osseous plate developed between the scapula and the vertebral border. The plate had been removed sub-periosteally some years ago, and had recurred, so that a second operation had been required. Such cases were extremely rare.

*Card specimens.*—Mr. MILLS: (1) Rectum excised by Kraske's method; (2) specimens of preputial calculi;

(3) specimens illustrating fracture-dislocation of the spine. Mr. CAIRD: (1) Specimens and photographs from case operated on for high shoulder; (2) carcinoma of transverse colon, from a case of resection and primary suture.

#### NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

MEETING HELD AT SHEFFIELD, NOV. 15TH, 1901.

The President, T. B. GRIMSDALE, M.B., in the Chair,

##### SPECIMENS SHOWN.

Dr. J. H. KEELING (Sheffield): 1. A semi-solid ovarian tumour, probably malignant. Owing to its attachment to, and involvement of, the fundus uteri it was found necessary to remove the uterus, together with the growth, by abdominal hysterectomy. The patient made a complete recovery. 2. Uterus with fibromyomata removed by abdominal hysterectomy.

Mr. PERCIVAL BARBER (Sheffield): A large subperitoneal fibromyoma removed with the uterus by abdominal hysterectomy.

Mr. R. FAVELL (Sheffield): 1. Fibromyomatous uterus removed by abdominal hysterectomy from a patient, *æt.* 54, the indications being recent rapid increase of growth and profuse menorrhagia. 2. Unruptured tubal gestation removed by laparotomy at the end of the third month. 3. Ovarian dermoid removed by vaginal coeliotomy.

Dr. J. W. MARTIN (Sheffield) exhibited an improved form of bed bath for use in douching.

Dr. ARNOLD W. W. LEA (Manchester) related a case of

##### PROFUSE HYDROPERITONEUM

associated with fibromyomata of the uterus. The patient, *æt.* 44, 5-para, had suffered from profuse, but painless, menstruation for three years. During the last four months the abdomen had become much distended by free fluid. The patient was much emaciated and suffered from pressure symptoms. The heart, lungs, and liver were normal, and there was no albuminuria. Per vaginam, the pelvis was found to be occupied by firm, multiple tumours, apparently of uterine origin. Three gallons of fluid were removed by tapping, and the growths could now be felt filling up the pelvis and lower half of the abdomen and apparently fixed. A fortnight later, as the fluid had re-accumulated, abdominal section was performed. The tumour was uterine, quite filled up the pelvis, and was adherent to the rectum. As removal was impossible, the ovaries and tubes, apparently healthy, were removed and the abdomen closed without drainage. The patient made a rapid recovery, and six months later had regained her usual health. At the present time, eighteen months after operation, the uterine tumour had become quite small and mobile, and there has been no return of the hydroperitoneum. The points of interest are (1) the rarity of hydroperitoneum in cases of fibromyoma; (2) the absence of any obvious cause for it in this case; (3) the clinical resemblance of the symptoms to those of malignant disease; (4) the beneficial results of removal of the appendages in causing shrinkage of the growth and cure of the ascites.

Remarks were made by the President (Dr. Grimsdale) and Dr. J. E. Gemmell, and Dr. LEA replied.

##### CANCER OF THE CERVIX—CÆSARIAN SECTION.

Dr. J. E. GEMMELL (Liverpool) described a case of cancer of the cervix with eight months' pregnancy, for which he had performed Cæsar section and abdominal hysterectomy. The patient, *æt.* 42, had been married twenty-one years, with twelve pregnancies—six children, five abortions, and the present pregnancy. At the sixth month there was some bleeding. This recurred at the eighth month, when extensive cancer of the cervix was discovered. Labour came on spontaneously, but natural delivery being impossible owing to the condition of the cervix, Cæsar section was performed, the fœtus removed being dead and macerated. The ovarian and uterine arteries were ligatured, and the



uterus amputated above the cervix. The cervix was then removed per vaginam, after division of the anterior and posterior fornices in the usual way. It was thought there would thus be less risk of peritoneal infection than by the abdominal method. The abdomen was drained per vaginam. The cervix on examination was a hard, scirrhous-like mass, its canal only admitting a cedar pencil. On section the surface was hard, white, and shiny. The growth involved the whole of the cervical walls, and completely surrounded the canal. Microscopically its structure was that of a carcinoma with an excess of stroma. The patient made a good recovery from the operation, but two months afterwards she died with secondary growths in the liver and stomach.

The case was discussed by Dr. Arnold Lea, Dr. E. O. Croft, and the President (Dr. Grimsdale), and Dr. GEMMELL replied.

Dr. GODFREY CARTER (Sheffield) read a paper on a series of

#### COMPLICATIONS DURING PREGNANCY AND LABOUR.

He referred to cases of placenta succenturia, adherent placenta, and post-partum hemorrhage, and urged that while the contractions of the uterus during the third stage should be favoured and watched, the uterus should not be bullied to do work which it was not ready for by premature attempts at expression of the placenta. Two cases of labour during the course of acute croupous pneumonia were described. A case of convulsions originating during pregnancy unassociated with albuminuria was quoted, in which the convulsions reappeared in the second pregnancy. On both occasions no convulsions occurred during labour or the puerperium, but the patient has since become an epileptic.

A discussion followed, in which Dr. J. E. Gemmell, Dr. Japp Sinclair, Mr. C. J. Wright, and Dr. E. O. Croft took part, and Dr. GODFREY CARTER replied.

## Lunacy Department.

### ASYLUM REPORTS.

#### PROPOSED NEW EDINBURGH ASYLUM.

In lunacy circles much interest is at present centred on this asylum which the Edinburgh District Lunacy Board purpose building at Bangour for their pauper patients. It is to be constructed on what is known as the "cottage system," and the proceedings of the Board, who are at present at loggerheads regarding the cost, are eagerly watched. We have again and again agitated against expensive asylums, and, so far as we can judge, this is going to prove the most expensive one in Scotland, both for construction and management. This question of cost is the subject of so much comment that we are inclined to think the motto of some asylum committees must be "more expense, more honour." The real advantages accruing from this system of asylum construction have not yet been fully demonstrated, and we are just afraid it will be pushed for more than it is worth, and that this Board may find, too late, that they have overleaped themselves. At a recent meeting the clerk reported that the expenditure in connection with this new asylum to December 1st last was £85,874 19s. 10d. The total cost of the railway alone is estimated at £33,000. The total cost of buildings for 600 patients, as estimated by the architect, is £263,230, and for 1,000 patients, £376,840. These figures speak for themselves, and at a glance indicate considerable extravagance, and thus furnish us with another instance of reckless and foolish expenditure of public money in connection with the construction of an asylum. The plans have been criticised by Drs. Fraser and Macpherson, Commissioners in Lunacy, and, appended to the clerk's report was a memorandum by them, in which they stated that the plans showed throughout unnecessary costliness in matters of detail. Instances of this were too numerous to individually specify, but examples were given, such as mullioned windows (shown almost everywhere), crow-stepped gables, string courses, and expensive mouldings in doorways, gables, &c. The coal stores attached to the workshops are surrounded by stone

balustrades, which serve no purpose. All these things must add greatly to the cost of the various buildings, and they will undoubtedly add nothing to their means of caring for or curing the insane. The Commissioners, however, also state that the plans showed abundant evidence of the most careful consideration with a view to facilitating administration and meeting the wants of the patients. This we are glad to learn, as it speaks well for the architect and the Board, and tends to condone for their general want of economy. The workshops, which would in ordinary commercial life be plain and simple, include some of the costly features already referred to. The very idea is preposterous, and no wonder they are estimated to cost £11,900. A home for thirty-six quiet, chronic patients is estimated to cost £6,470, or £180 per bed. We much regret that a home for this class of patients, for whose care the simplest arrangements would suffice, should be so expensive, and very wisely the Commissioners did not recommend its erection. It is also proposed to spend £2,000 on a mortuary. We do not require to enlarge on the glaring extravagance which is exhibited here, on a building which should be quite unobtrusive. It would be more to the purpose to spend two-thirds of this money on the full equipment of a pathological laboratory, which would further the interests of science. It is all very good to make a fine outward show, but what is the return? Is the recovery rate thereby increased? Is the death rate diminished and the cost of maintenance less? Certainly not. Why then this needless expense? Then, again, will not the hard-headed ratepayer crown all with the question, "What have we got for our money?"

#### HOLLOWAY SANATORIUM.

The House Committee report that on January 1st, 1900, the number of patients and boarders was 404, and on December 31st, 391; the average number during the year being 401. They again remind us of the fact that there is no endowment, and that in developing the charitable working of the hospital they must necessarily proceed with caution. A large proportion of paying patients must be maintained so as to provide the means for admitting others on a charitable basis. The Committee have very generously granted weekly allowances to the wives and families of five men of the ordinary staff on active service. We are pleased to note that the case books, which are illustrated—a pleasing feature—are always well commented upon by the Commissioners in Lunacy, and this must be very gratifying to the medical officers. During the year 10 general paralytics were admitted on the male side, a high percentage. Dr. Moore does not speak favourably in his report of voluntary patients. He thinks they do not exercise a good influence on the other patients, and we quite agree with him.

#### DERBY BOROUGH.

Dr. MACPHAIL reports that in the admissions 42 per cent. suffered from possibly curable forms of mental disorder, and that a less proportion than formerly suffered from grave forms of brain disease. He justly points out the tendency each year to send more senile and helpless cases to asylums. We regret to confirm this statement. Many cases are now sent to asylums which, until a few years ago, would have been cared for in their own homes or in a workhouse, and this perhaps accounts for much of the apparent increase of lunacy. The admission rate is not high—94 admissions, 44 discharges, and 44 deaths. The death rate (14.4 per cent. on the daily average number resident) is high, but a severe epidemic of influenza indirectly accounts for this. A study of the causes of insanity shows that alcohol is responsible for 21 of the admissions. Dr. Macphail's report indicates evidence of efficient management.

Dr. CLARENCE ALLERMAN, a young medical man, died at Rotherfield from injuries received while cycling. He was riding from Rotherfield to Eridge and was thrown from his machine. Dr. Allerman was a lieutenant in the 1st Cinque Ports Rifle Volunteers.

## Special Articles.

### PTOMAINÉ POISONING.

THE occurrence of a well marked case of ptomaine poisoning on the 9th inst. in Cork is of more than local importance. Four young children on Saturday morning, the 7th inst., eat some tinned salmon, the tin of which was opened on the day before. One of the little ones, a girl two years and eight months old, became very ill; she suffered from purging and vomiting, and finally died in a state of collapse early on Monday morning.

The word ptomaine is derived from the Greek *πρωμα*, a corpse. It has been defined as an alkaloid body formed from animal or vegetable tissues during putrefaction by the agency of pathological bacteria, or, more briefly, as a putrefactive alkaloid.

The fact that many distinguished chemists deny that ptomaines have any alkaline re-action, or are capable of forming alkaloidal salts with acids, and cannot be looked upon as amines, for some of them are amido-acids; amido-acids like creatinin and neurin we will not discuss. The word carries a certain specific meaning to the medical officer of public health and to the medico-legal jurist, though it does approve itself to chemists like Salkowski, or physiologists like Brieger. In 1863 Marquardt isolated a crystalline substance which in its action resembled conine; since then many such bodies have been discovered, one of these, gadinine ( $C_7H_{10}NO_2$ ), is obtained from decaying fish; it is one of the most active and lethal of the ptomaines. Its effects are those of a virulent vegetable alkaloid. Indeed, it was this close similarity to alkaloidal poisoning in Italy, where for centuries poisoning has been reduced to a fine art, that first directed Marquardt's attention to the subject. He extracted from the body of a man, who was supposed to have been poisoned, a substance which closely resembled delphine ( $C_{22}H_{33}NO_3$ ), but which tested physiologically was found to differ from it.

One of the peculiarities of gadinine is that many persons are unaffected by it even in large doses, and others are very susceptible to its toxic properties. In Dr. Mann's case six persons ate of tinned salmon, but only one died; in this Cork case, of the four children one suffered. An explanation for this is offered by the statement that the meat packed along the outer rim of the bottom of the case is more unwholesome, richer in ptomaines, than the rest of the contents of the tin. But tinned meat when properly canned is a wholesome and nutritious diet, and it would be a misfortune to the poor if a prejudice were to arise against its use.

The canning of meat was made the subject of a special inquiry by the Agricultural Department of the U.S.A., and the report states that weight for weight tinned meat contains a much greater amount of nitrogenous material, while the proportion of fat in tinned and fresh meat is almost the same.

Of the total proteid in canned meat Notter and Firth find that not more than 2 per cent. was indigestible. If, however, bad meat is used, or the meat is badly cooked, or the tinning process is not properly carried out, there is death in the pot.

The purchaser's best protection against danger is in the brand of some respectable firm; besides this there is the further protection of the bulging of the ends of the tins, which tells that the contents have commenced to decompose. On being opened the contents of the tin, on being turned out on a plate or deep vessel, should give off no bad smell, and should be free from discolouration. As a further precaution, all tinned meats should be cooked immediately the tin is opened. Tinned fish will develop ptomaines if left in the open tin, in twelve hours, unless they are protected from putrefactive dangers by some chemical agent. They should never be given uncooked to children, and certainly not to children under seven years of age. Should toxic symptoms develop, they must be treated as they arise; there is no antidote to the ptomaines, and unfortunately nature's efforts to eliminate the poison are too often attended by inflammation of

the alimentary tract, which oft-times extends throughout its whole length. Early in the attack the heart suffers, its contractions are imperfect, weak, and very frequent; all the muscles, voluntary and involuntary, share in the general prostration; the skin is bathed in sweat, which soon becomes cold and clammy; the heart becomes very weak, the pulse is not to be felt, and the patient becomes so prostrate that the vomiting ceases from inability of the stomach to reject its contents; the relaxed anal sphincter allows of the bowel to empty without effort; the patient complains of cramp in the calves of the legs, and death soon after releases the sufferer from his agony. The evil of ptomaine poisoning is best guarded against by the inspection of all cans of tinned meats offered for sale by the sanitary inspector from time to time, and the destruction of all cans which are in the least convex at their ends.

### CENTENARIANS.

CENTENARIANS, like so many other prodigies—physiological, physical, and moral—come forth from time to time in definite groups. At present they are well in evidence. A century or so ago the authentic—or even physically possible—existence of a human centenarian was questioned by the sceptical. It was indeed absolutely rejected by some of the best informed inquirers. There can be no doubt that many specimens claiming to belong to this class of chronological monsters were invented by the manufacturers of folk-lore and fairy tales, in the good old days when registration of births and baptismal records were not so faithfully carried out and so carefully preserved as they have been of recent years. Accordingly, the evidence of an actual centenary span of existence has been entirely rejected in the cases of the most miraculous specimens by all careful critical inquirers. But, on the other hand, if the noble army of centenarians has been reduced in number, the existence of a limited number has been placed in a position which is historically and scientifically impregnable. In the *Lancet* of November 9th there appeared a short notice of the death of Mrs. Elizabeth Hanbury, of Richmond, Surrey, at the super-venerable age of 108 years and 4 months. This interesting article has had the further desirable effect of eliciting from Mr. T. E. Young, one of the highest authorities on this interesting subject, a communication which appeared in the following issue of our contemporary, where he mentions that he has, since the publication of his well-known book on the subject in 1899, obtained incontrovertible evidence of the existence of twenty-two additional cases. There is at least this consoling consideration to soothe all of us in our age of universal hurry and worry that the whole weight of scientific evidence, which has been so carefully collected and so accurately collated of recent years, goes to prove that the span of average human life is lengthening. The additional comforts, the improvements in sanitation, and the almost universal diffusion of some sound views of hygiene have hitherto more than compensated—at least in the Old World—for the effects of the increased speed which is now so necessary in the race for "success," and for the increased competition which growing population and the erection of the standard of skilled labour—mental as well as physical—have created in every locality and in every profession and occupation of life. So that it would seem that the ground is gradually sliding from beneath the feet of the ignoble army of pessimists. Many enthusiastic scientists, especially those who are still under the age of forty, express with confidence the prophetic hope that before the end of the twentieth century the genesis of all pathogenic microbes will be brought under absolute control. If not then actually wiped off the face of this planet, their entrance into, or their subsequent development in, the tissues of the human body, will have been effectively provided against. The progress of science during the nineteenth century does—most assuredly—give us some reasonable grounds for such an outlook. Then the office of the physician will no longer include the cure of disease. He need only maintain the efficacy of his scouts and outposts to give warning of the approach of microscopic enemies, if any

happen to be still left. And all his other energies may be devoted to the lengthening of human life, and the further development of the physical and mental powers of man. Mirage-like visions of the future thousand-year existence of *homo sapiens* will probably loom over the heated sands of the desert of life as we progress in the pilgrimage of the twentieth century. Many conservative persons will still quote the inspired writer who metes out the life of man with the standard measure of seventy years. And the radical sceptic will scout the approximate record of the age of Methuselah by informing his opponents that the astronomy and chronology of the Book of Genesis are those which the captive Israelites learned at Babylon, where the "year" was measured by the moon instead of the sun; and, accordingly, contained but twenty-eight days instead of three hundred and sixty-five.

The other conspicuous instance of centenarian longevity which has been so recently reported is that of the Dowager Lady Carew. This lady was born in the County Waterford, Ireland, in the historic year of 1798—"the year of the French" of the Western Irish, who universally refer to it by this epithet from the fact that in that year a body of invading Frenchmen landed at Killala, marched for Sligo, were opposed at Carrick-na-gat by Harloe Knott, of Battlefield, who rapidly marshalled the yeomanry of Sligo, routed the misguided invaders, and pursued them in their retreat inwards—where, meeting further opposition and no effective aid from the disaffected natives, they surrendered at discretion in the village of Ballinamuck. The late Lady Carew figures prominently at another conspicuous date of Anglo-French history, having been present at the famous ball given at Brussels on the eve of the battle of Waterloo. This venerable lady died on the 12th ult., in her 104th year, having thus lived in three centuries.

### Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, Dec. 21st, 1901.

At the Medical Society Hr. G. Klemperer gave an address on

#### THE ORIGIN AND PREVENTION OF OXALATE RENAL CALCULI.

It was a custom, he said, that when an individual voided a stone with acid urine to order something suitable for the treatment of uric acid calculi. If the stone in question were an oxalate such treatment would be injurious and would certainly lead to recurrence. If the stone were really an oxalate the situation would be difficult, as up to the present no means had been determined by which a return of the symptoms could be prevented. The speaker, in association with Tripstein, had carried out a series of investigations in the Institute for Medical Diagnosis, and had ascertained that oxalates were not so infrequent as had been supposed. In sixteen cases oxalates were met with five times. In Israel's practice 54 per cent. of the calculi were formed principally or in part of oxalates. The question of prevention was covered by that of the origin of oxalate of lime. According to general opinion this was of alimentary origin; spinach especially contains a large quantity of it, about 110 mgrm. in 100 gm. The gastric juice dissolved the greater part, and 25 to 30 mgrm. passed into the urine. As to what became of the remaining 75 mgrm., he was of opinion that it was not destroyed in the tissues. The greater part of the oxalate of lime was destroyed in the intestines, and traces only were found in the stools. He had injected minute doses of oxalate of lime into mice and dogs, and found that all passed off smoothly in both animals. It was not therefore destroyed in the tissue

changes, but what appeared in the urine was absorbed from the stomach. Although oxalates appearing in urine were of an elementary nature, the avoidance of vegetable and fruit in the diet could not ensure urine free from oxalates. The reason for this was not understood until Sommel, of Munich, showed that when gelatine was given 4 to 15 mgrm. of oxalates were found. This discovery drew the speaker's attention to glycochol, which was known to be a solvent for oxalates. Now kreatine was a glycochol derivate that played an important part in the system. It formed both urea and oxalic acid. The glycolic acid present with bile was also important, as when this was absorbed glycochol became free, and the formation of oxalates was possible. In the icterus of resorption also oxalic acid became free. These facts tended to an explanation of the origin of oxalates. The aim now should be not to avoid substances containing oxalates, but to facilitate its solution in the urine. The double phosphate of soda, he thought, was not sufficient for the purpose, but there was another material that acted in the right direction—magnesia. It had been shown that oxalate of lime was soluble in salts of magnesia when heated. A milk diet was unsuitable, as it was poor in magnesia and rich in lime. If food was divided according to its richness or poverty in lime into two groups, vegetables would belong to the first, and to the latter fish and the different kinds of meat. Milk and eggs were to be carefully avoided when there was a tendency to oxalates. In cases with such tendency he should therefore recommend the avoidance of milk, eggs, and vegetables, and in their place recommended flesh, vegetables, and farinaceous foods, and in the way of medicine two grains of bitter salts daily in oblates.

Hr. Senator considered that Klemperer's results threw a clear light on to a hitherto obscure subject. In confirmation of the statement made he observed that children suffered with extraordinary frequency from oxalic calculi in consequence of their milk diet rich in lime, and remarked on the success that had followed his treatment during the last three years, which consisted in feeding with material free from lime—flesh, fish, potatoes, bread, and apples, a diet which corresponded on the whole to the principles enunciated by Klemperer.

At the Society for Psychiatry and Nervous Diseases Hr. F. Krause showed a

#### CASE OF TRIGEMINAL NEURALGIA AND CICATRIX EPILEPSY TREATED BY EXTIRPATION OF THE GASSERIAN GANGLION.

The case was not shown as one of recovery, as it would take several years to effect that. The patient was 48 years of age. His grandmother died in an asylum, but all other relatives have been free from nervous disease. Up to Easter, 1897, he was quite well, when he had a fall down some steps and struck the margin of the left orbit. Neuralgic pains soon followed, at first in the left supraorbital region, then in the infraorbital, and latterly over the whole of the trigeminus region; later on the occipital region became affected. Three operations had been performed elsewhere; in 1898 resection of the infraorbital nerve, then of the second branch. The latter operation was successful for a time as regards the pain, but epilepsy soon after set in. At the third operation the third branch of the trigeminus was resected. This gave a negative result. The patient was so depressed by pain and

fits that last summer he attempted to commit suicide. He was taken into the Augusta Hospital in September last. Here he had repeated attacks, with loss of consciousness, cyanosis, stertor, sweating, tonic tension and clonic twitchings, fixation of pupil, loss of sensibility, and consequent somnolence. An attack could be started by pressure on the scar on the face. It was known that improvement followed excision of the cicatrix in suitable cases, but here the cicatrix was very deep, and, whatever was done, a cicatrix would still be left. He therefore decided to remove the Gasserian ganglion, so as to permanently interrupt the stimulus passing to the brain.

Since 1892 he had performed the operation thirty-five times, and had never seen a recurrence. Regeneration of the ganglion could not take place. The preparation shown contained the trunk of the trigeminus, the Gasserian ganglion, and the stump of the second and third branches. So far the epileptic attacks had not returned, and the pain had disappeared. There was still some neuralgia in the occipital region, but much milder than before. In reply to various speakers, he said that facial deformity could not always be avoided. The deformity observed in that case resulted from Lucke's operation. Spasm of the jaw was very apt to follow that; the patient had it, but it improved after removal of the ganglion. The masticatory muscles were paralysed by it, and the mouth drawn a little to one side by the action of the external pterygoid muscles.

## Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, Dec. 21st, 1901.

### HOT-AIR TREATMENT.

At the "Gesellschaft der Aerzte" Roth showed an apparatus which he thought would overcome the three difficulties against the present in use. His apparatus has a double wall which obviates the hot air coming into direct contact with the body, as it circulates in the interspace, which overcomes the danger of burning. The apparatus can be warmed up gradually and is regulated by a ventilator.

### ELECTRIC EXPERIMENTS ON DOGS.

Jellinek demonstrated a dog on which he acted with 500 volts. As soon as the current was turned on the animal was attacked with opisthotonos contraction and paresis of the hind legs which lasted twenty hours, afterwards completely paralysed. Forty-eight hours later incontinentia alvi et urinæ; still later complete paralysis of motility and sensibility, with loss of reflex action, were prominently marked, while the degenerative reaction was quite absent.

Three days later the conditions began to improve in the order in which they appeared. The site of the lesion is evidently located to the spinal cord, which may be either hæmorrhage of the spinal structure or located to the meninges. It may also be a sort of ischæmia caused by a spastic condition of the blood vessels, or lastly it might be the result of a specific action of the electric current acting on the ganglionic cells.

### SUPLANTING STITCHES.

Frank showed the meeting a new device for closing wounds without stitches. Nickel silver strips are rolled up with a fine point at one end, which is run through the lips of the wound and drawn together and

finally closed with a pair of forceps. Frank claims a large number of advantages too numerous to enumerate here.

### TUBERCULOUS PROPHYLAXIS.

Koonfeld showed a series of objects which were manufactured from asbestos that can be easily sterilised in the fire. These comprised spoons, spittoons, mantles for ladies and other parts of furniture necessary in a sick room. The articles are light and portable, inexhaustible in variety, and commended for their cheapness, as a spittoon will cost four hellers only, or 0.4 of a penny!

Weinlechner asked how high a spittoon should be placed in a sick room for a patient, as the floor was a dangerous position for it. Koonfeld thought the chest was a good height.

### FURUNCULOSIS.

At the "Doctoren-Collegium" Gersung gave a lecture on minor surgery which comes under the observation of an every-day practitioner.

Furunculosis was a common morbid process that a wet compress would bring to a head, which could then be opened. When it was confined to the hair follicle a drop of nitric acid would be found effectual. When the process has spread infiltrating the surroundings from a cylindrical pustular sac the scalpel should be inserted, and the necrotic tissue removed with a scoop, after which a little dermatol or other antiseptic may be inserted. In multiple cases the galvano-cautery is useful. In the case of children, opening and leaving them with light compress will be found efficient.

### CARBUNCLE OR ANTHRAX.

This is somewhat allied to the former both in origin and treatment. It seems that the cocci gain admission by the skin burrowing deep into the cellular tissue and affecting the skin secondarily. Poultices will soothe the wide surroundings best, and when well advanced a cross or star incision will be found most effectual. The scoop and iodoform gauze will be the best dressing.

### PANARITIUM.

This often commences in the skin, passing on through cutis, subcutis, to the periosteum, or tendinous sheath. An early puncture for pus should be performed by cocainising the part and using a Pravaz syringe. A deep opening should be made, and the dressing put well down to the bottom of the cavity with a drainage tube.

### RETROPHARYNGEAL ABSCESS.

In opening these it is necessary to have an assistant, although instruments have been devised in a sheath to modify the danger, but notwithstanding this protection with metallic coverings the patient will suddenly recede before the edge is covered. With a pair of long forceps the wound dilated and discharged, afterwards inserting a tampon.

### BURNS.

In case of burns fibrous dressing should not be used, as the fine texture becomes entangled in the terminal nerves, and gives unnecessary pain. A soft, oily dressing, covered with gutta percha, will be found most soothing.

### DERMATITIS SERRIGINOSA.

A morbid process of the rete malpighii healing without leaving any scar. It should be brushed over with a strong solution of nitrate of silver. A compress with rectified alcohol is often quite efficient. Intertrigo in fat people may be similarly treated by sponging the part with rectified alcohol.

## The Operating Theatres.

### THE HOSPITAL FOR SICK CHILDREN, GREAT ORMOND STREET.

**CASE OF PROLAPSUS RECTI.**—MR. STANSFIELD COLLIER demonstrated the following treatment in a case of a girl, *æt.* 2, suffering from prolapsus recti. Several inches of bowel in a congested and somewhat ulcerated condition protruded. The history of the case was as follows:—The prolapse had been down every day for four months. At first it came down during defæcation only, and was readily returned, but there had been increasing difficulty in returning it, and for the last week it had been down all the time, and attempts at reduction had not succeeded. The case had been under Mr. Collier's care in the out-patients' room, and the ordinary methods of treatment had failed. Mr. Collier reduced the prolapsus under chloroform, remarking that the anal mucous membrane formed no part of the prolapsus and was natural in the sphincter region. He then introduced the fine needle of an exploring syringe through the ano-coccygeal ligament midway between the anus and the coccyx until he felt the point of the needle; behind the rectum, by this means, he injected into the superior pelvic rectal space about four ounces of saline solution of the strength of two drachms to the pint (double the strength of normal saline solution). The finger in the bowel now felt a cushion-like distension behind and at the sides of the rectum. As the child came round from the anæsthetic it was plain that its efforts to reproduce the prolapse were only partially successful, although the sphincter was much relaxed. Mr. Collier requested the house surgeon, Mr. Curl, to repeat the injection at the end of forty-eight hours. Mr. Collier said that the mechanical distension would temporarily prevent the descent of the prolapse, and that the salt, acting as an irritant would produce some induration of the cellular tissue, the yielding of which tissue was an important element in the production of prolapse. In this case the prolapse occurred in the course of a summer diarrhœa. He said he had heard that prolapsus recti was extremely common in famine camps where the very much-wasted child is suddenly placed on full diet; here the loss of the pelvic padding of fat is probably an important factor. Mr. Collier expressed his intention of giving this method of treatment, which he considered to be harmless, an extended trial next summer.

The child operated on was seen two months later, and was found to have no return of the prolapse.

#### The Mortality in Foreign Cities.

THE following are the latest official returns, and represent the last weekly death-rate per 1,000 of several of the populations:—Bombay 52, Madras 69, Brussels 15, Amsterdam 13, Copenhagen 14, Stockholm 15, Christiania 15, St. Petersburg 23, Hamburg 18, Munich 22, Vienna 16, Prague 24, Buda-Pesth 17, Trieste 27, Rome 13, Venice 25, New York (including Brooklyn) 17, Philadelphia 17.

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## The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, DECEMBER 25, 1901.

#### ACTIVE AND INERT VACCINES.

THE importance of securing efficient vaccination and the uncertainty of action of many, or at any rate of some, of the vaccine lymphs in the market, invest the methods of preparing these lymphs with special interest at the present juncture. It is urged, not without some plausibility, that so delicate a process of preparation ought not to be left in the hands of private persons, and that its preparation ought to be monopolised by the State. Others have urged that the State should at any rate exercise a close supervision of the private institutions where vaccine is prepared in order to ensure, as far as is humanly possible, that only active and thoroughly trustworthy products shall be issued to the profession. It is hardly open to question that many of the instances in which vaccination has failed to protect against subsequent infection with small-pox are to be attributed to the fact that the operation has been performed with inert lymph and the scientific status of this protective measure has thereby been jeopardised. In spite of all the skill and labour that have been devoted to the study of the technique of vaccine production, no absolutely certain means are yet available of ensuring a constant and unvarying supply of really protective lymph. This holds good in respect of all vaccine laboratories, not excepting those carried on under Government control, and this is a strong argument against conferring any sort of monopoly in its production. It is a common experience, that, notwithstanding every precaution, identical methods do not always yield identical results. Laboratories are subject to periods of what a distinguished orator would call “rank bad luck,” that is to say, certain series of inoculations of calves yield a lymph which proves inert. The closest supervision cannot be relied upon to prevent these seasons of lymph famine

and the sterility may affect laboratories widely distant. Moreover, Government supervision implies the power to impose particular methods, and as the experts of whom the supervisory committee would consist would naturally consider their own methods the best, uniformity of method would be insisted upon, and the risk of concurrent failures would be enhanced. Lymph may be inert under at least three different sets of conditions; it may be inactive *ab origine*; it may spontaneously lose its protective qualities in an unusually short space of time, or it may be subjected to vicissitudes of temperature, &c., which are inimical to its retention of activity. Lymph which is inert from the beginning ought never to find its way on to the market, because it is the duty of every superintendent of a vaccine institute to make sure, by repeated tests, that his products possess the requisite degree of activity. Moreover, the process of sterilisation in respect of foreign organisms necessitates the lymph being kept under treatment for at least a month so that a further opportunity is provided of gauging the stability of the product. Lymph kept for a longer period in stock should be periodically tested, and in this way, although the institute may find itself in possession of inert lymph, this need never be placed in the hands of practitioners. One other cause of loss of activity is too free dilution with glycerine, but directors of institutes may be trusted in their own interest not to carry the process of dilution beyond a safe proportion, which experience has shown to be about one part of vaccine pulp to four of glycerine and water. The best, indeed the only, method by which a lymph famine can be avoided would be by forming a sort of syndicate of vaccine institutions, so that when the tests show that the lymph in the course of preparation at a particular establishment is inert a fresh supply of active material can be obtained from another institute not similarly afflicted. The only test of the efficiency of lymph is on the child, for lymph which may give a satisfactory reaction on the calf may fail when applied to the human being. Every specimen of vaccine lymph should be dated, and the origin and effects thereof carefully noted, in order to minimise the risk of products which have become inert continuing to be issued.

#### INJURIES FEIGNED AND REAL IN THE MEDICO-LEGAL ASPECT.

WITH the advances of civilisation and the increase of knowledge, comes, *pari passu*, the increase of skilled criminals. The engineer who invents new instruments, and modes of making instruments, finds that as well as benefiting his fellow-workers, he has helped the skilled burglar. The chemist, who spends his days and nights in research finds that one of the ultimate results of his labours is to facilitate the murderer. The philanthropist who works for the spread of education finds that as his pet schemes advance so do forgery and its allied crimes. It would be hopeless, then, to expect

that medical knowledge could escape from furnishing assistance to the would-be rogue or criminal and keep herself free from the reproach which is sometimes liable to overtake her sister sciences. Perhaps the rogue's most favoured method of using medical knowledge consists in bringing a small quantity of it to the aid of a large degree of moral laxness—to use a mild term—in order to convert himself into the skilled malingerer. Malingering in its rudiments, is probably as old as the world, but, as each succeeding century sees fresh changes and advances, so the form which the malingering takes becomes altered and presents fresh phases. Like epidemics, waves of malingering of species suited to the conditions present appear to sweep over countries. At present, perhaps, the most favoured species is to be found in the feigning of injuries alleged to have been received owing to the carelessness of some large company, who are known to be capable of paying indefinite damages. This species of malingering has infested our own country for many years, and it is by no means strange to find that a similar evil exists in America. The following extract from a paper by Dr. Ott, of Philadelphia, brings this forcibly home to our readers and reminds them that they have heard of very similar doings at this side of the ocean:—  
 “A species of modern robbery, which has grown to enormous proportions, is found in accident cases, and with these the neurologist is more or less associated. Modern transportation has greatly increased the number of accidents, and, as these cases are subject to jury trials in questions of liability and damages, an abuse has grown until the larger corporations often pay unjust claims rather than submit the question to a prejudiced jury. The professional complainant for damages is a modern production, and in our larger cities one-fourth of the cases possess this blackmailing character. The city electric lines lose from 300,000 to 500,000 dols. annually, and many of the cases are trumped up and pampered for the occasion by the unscrupulous collusion of lawyers and physicians, who agree to divide the gain among themselves. Observe very closely a damage suit at trial and note with what detail the complainant's case has been mastered and how some innocent perversion of function is enlarged and given an importance, how a trifle is made to appear as the most excruciating suffering and what a possible or positive permanency is attached to each disturbed function, to influence an ignorant set of laymen towards bringing a heavy verdict for the plaintiff. On the other hand, note the weakness of the defence in the utter absence of valuable medical testimony or a physician who has made but one examination, and that in the latter part of the trouble, and who is now supposed to know as much about the case as the one in charge from the inception of the injury to the time of trial.”  
 This quotation is as applicable to these countries as to America, save for one particular. Here, we are proud to be able to say, there is no “unscrupu-

lous collusion between lawyers and physicians." The difficulties which beset the position of the medical man in these cases are the opportunities of the rogue. The relative impossibility of determining within a short time the existence or degree of presumably deep-seated nervous injuries, renders impossible, even in the case of the most skilled medical man. Dr. Ott makes suggestions of importance as to the means of detecting the reality or not of alleged injuries, and passes stern criticism on the present-day mode of adjudicating these most difficult cases. His criticism in many points coincides with much of what we have written on this subject on a previous occasion. "Imagine," says Dr. Ott, "a butcher, a baker, and a dry-goods merchant passing judgment upon traumatic neuroses, such as paraplegia, neuritis, palsies, impaired vision, and the various disturbances of locomotion incident to the graver accidents. How often in cases where the plaintiffs are women, who were but slightly injured or more likely not injured at all, is the hysterical or neurasthenic element produced. Medical and expert testimony in accident cases is the opprobrium of the profession to-day, and the sooner such questions are considered from a scientific standpoint the greater the honour will be accorded to the medical profession. The physician is the only one that can differentiate the feigned from the real sufferer, and judiciously pass opinion upon the nature and degree of the injury, and the amount of damages to be awarded. Let the layman confine himself to questions of liability alone."

#### THE LONDON SMALL-POX EPIDEMIC.

THE apprehensions which have been expressed as to the future course of the epidemic of small-pox in the Metropolis are apparently approaching realisation. The first death was registered in the week ending August 3rd, and the total number of deaths to the end of last week amounted to 179. The returns point to a steady increase of the malady. During the first fifteen weeks of the outbreak the cases under treatment were respectively 11, 13, 41, 74, 92, 137, 153, 169, 175, 172, 180, 284, 297, and 368. During the past four weeks the figures have been 396, 427, 474, 506, and 528. There were 134 fresh admissions last week, as compared with 141, 123, and 170 in the preceding three weeks. These facts more than warrant the vigilance and anxiety displayed by the various local and central authorities of the Metropolis with regard to the outbreak. In view of the alarming and steady increase of the disease it may be interesting to recall some of the figures relating to the history of the disease in former London epidemics. In the year 1838 the local incidence of mortality from small-pox reached 31,817 per million living. Later, in the year 1853, came the great disturbing factor of vaccination, which was then made compulsory by Act of Parliament. For some years, however, vaccination was administered in a perfunctory manner, until, in 1867, the Act was strengthened and rendered more efficient, the deaths

at that period being at the rate of 457 per million. In 1869 the figures fell to 87 per million, but rose again in 1872 to 302, and in the disastrous epidemic of 1871 to 2,422 per million. After various fluctuations the London rate fell to 6 per million in 1886, to 2 per million in 1887, and to zero in 1889. Since that time the remarkable return of zero has been recorded again in 1898, while the highest rate in epidemic years has not been more than 48. These figures furnish a most striking proof of the efficacy of modern preventive measures, of which vaccination must be regarded as the chief. At the same time it may, of course, be freely admitted that bettered conditions of environment, both sanitary and social, have contributed to the happy result in question. The opponents of vaccination are wont with wearisome iteration to attribute the decline of small-pox solely to improved sanitary and preventive measures. They will perhaps within the next few years be able to test the truth of their theory, inasmuch as the public administration is likely not only to persist, but also to attain a higher standard. On the other hand, they will find ready for purposes of comparison a rapidly growing increment of population unprotected by vaccination, thanks to Mr. Balfour's retrograde Act which has complicated matters by the wholly gratuitous introduction of the "conscientious objector." Meanwhile, the close relations of the Metropolis to other towns of the United Kingdom renders the London outbreak an affair of national importance. From that point of view indeed, in these days of rapid transit, the outbreak may at any moment be distributed to the furthest corners of the world. There is one point that deserves notice, even at the cost of adding somewhat to the sum of the public anxiety, namely, the advent of the holiday season. Within the next week or two an enormous fluctuation of the population will take place between London and the provinces. It is almost too much to hope that small-pox will not be conveyed in some instances by the passage of infected persons. The return of a large number of school children to the metropolis is, perhaps, one of the gravest features of the case. We hardly believe, however, that the time has arrived for any highly alarmist view of the situation. The authorities have grappled vigorously with an emergency of no common order, and the infectious hospital accommodation and ambulance service are above reproach. Last, but not least, the populace have resorted to re-vaccination in a fashion that has become almost universal, a fact that in itself offers a proof of the sound sense that in the hour of need is prone to replace the prejudice of the average Englishman.

UNIVERSITY Scholarships were awarded as the result of the recent B.A., B.Sc., and M.B. examinations of the University of London—in Medicine, to C. J. Thomas; Obstetric Medicine, A. E. Jones; Forensic Medicine, E. M. Sharp. The same gentlemen also gained the gold medals.

## Notes on Current Topics.

### Objectionable Quack Advertisements.

MUCH has, from time to time, been written against the objectionable advertisements which are allowed to appear in what are otherwise respectable and high-class publications. Among the many ills which afflict the human race, and which are seized upon by the unscrupulous quack for swindling the ignorant, are those which affect the organ of hearing. Only a few months ago our contemporary *Truth* courageously and completely exposed the disgraceful swindle known as the "Drouet Institute," and their exposure led to the removal from the list of members of the Royal College of Surgeons of an individual who allowed himself to be connected with the said Institute. Yet the full-page advertisements of this body of charlatans are still allowed to disgrace the pages of respectable dailies. Similarly, despite numerous inquests, and actions successfully brought against them, the so-called Viavi Company is still allowed to advertise and pursue its baleful way unchecked. Unfortunately, it is but two decades since the branch of surgery which has to do with the treatment of diseases of the ear became a recognised specialty, and therefore the laity have as yet become scarcely educated in the matter. Hence the ear is a happy hunting-ground for quacks of all sorts. We could give numerous cases which have come under our personal observation in which sufferers have been robbed of various sums by the Drouet Institute when their diseases have been beyond relief. Quite recently we met with an instance of long-standing congenital syphilitic nerve deafness who had paid no less than £12 to these quacks. Looking through the Christmas number of a well-known magazine we find no less than three advertisements of otological quacks. One man, who describes himself as "M.D. (U.S.A.)"—a degree which, as demonstrated to the Battersea coroner in a cancer cure case, does not and never did exist—cures ear, nose and throat troubles by "aerial medication," and gives portraits of supposed patients. The other two advertisements relate to ear drums, one of which at least is of a dangerous nature, judging by the illustration. Since the Legislature does not move in the matter of quackery and illicit practice, and since the General Medical Council have, as yet, no powers to deal with the matter, there is but one remedy possible. Were the respectable magazines and newspapers to combine together to refuse the advertisements of these gentry their ill-gotten gains would greatly decrease, and they would soon find it not worth their while to continue to trade upon the credulity of the public. The papers themselves would not suffer, for there could be no lack of legitimate advertisements to fill the spaces vacated by the quack nostrums. Some months ago one of our judges spoke very severely upon the subject of abortion-mongers' advertisements, with the result that these objectionable paragraphs have practically ceased to appear in the newspapers. We almost

believe that could public expression be similarly given against the proclamations of other quacks the respectable journals would refuse them with equal promptitude.

### Fæces and Flatus per Urethram.

THE difficulty of determining the cause of the fistula which allows the escape of intestinal contents through the urethra is sometimes much greater than might be supposed. Not only so, but the discovery of the site of the fistulous communication may present very considerable difficulty. In many cases the primary lesion is so well marked, and has produced such definite symptoms, that the patient has been under observation and treatment for some time before the abnormal passage of fæces or flatus has occurred. Even in cases of congenital communication between the intestinal and urinary passages, the site of communication may not always at first sight be apparent. It appears to be possible that with a normal anus a congenital communication with the urinary passages may exist. Is it possible that such a congenital communication may exist, and yet fæces and flatus not pass *per urethram* for several years? The question is suggested by a case of recto-vesical fistula in a child reported by Dr. Sympton in the "Quarterly Medical Journal for Yorkshire and the Adjoining Counties." Unfortunately, no post-mortem examination was performed, but at a second operation undertaken for the closure of an artificial anus in the inguinal region, it is stated no attachment whatever could be found between the bladder and rectum. We assume that what is meant is that no communication could be found. There had been no history of any trouble which might be considered to have caused the fistula. So far as the report of this very interesting case goes it does not seem certain that the communication may not have been at the trigone of the bladder near the internal meatus, or even in the membranous urethra.

### The Indiscretions of "What's What."

IT is a remarkable psychological fact that the average layman is unable to understand that the maintenance of a high standard of professional etiquette is as much to the welfare of the community as for the comfort of the individual members of the profession. The man in the street says the ways of doctors are past finding out. Excuses may be made for him, but the same cannot be said for Mr. Harry Quilter, the editor of *What's What*, which modestly professes to be "A guide for to-day to life as it is, and things as they are." Mr. Quilter sins with open eyes. He gives a list of specialists he is pleased to consider "capable men in the various maladies alluded to." We trust Mr. Quilter has not had personal experience of all the "maladies" mentioned, although of the gentlemen he considers worthy of being recommended he says "we have had experience of them." We should like to know who hath made Mr. Quilter a ruler and a judge over us in this



matter. There is much that is amusing in this layman's nonsense. One physician is said to have "a most wonderful ear for diagnosis of all lung and heart complaints"; another, "though enormously overworked is second to none." A well-known alienist is said to have "great penetration and the most ingenious and matter-of-fact way of putting awkward questions." A curious mistake is made when Mr. Critchett, now Sir Anderson, is referred to as "the son of the late Sir Andrew." Really Mr. Quilter has made a mistake in the title of his work. We are afraid he will not have another opportunity of correcting it.

#### The Treatment of Grave's Disease.

ALTHOUGH our knowledge of the ætiology and pathology of exophthalmic goitre has considerably advanced during the last few years, the therapeutics of this disease has not progressed in at all the same degree. No single principle of treatment can be said to have been placed on an irrefragable basis. As is invariably the case when first principles have not been established, the list of so-called remedies is very extensive, and good results have been claimed for drugs of the most different, and indeed often antagonistic, action. The Gordian knot has sometimes, under somewhat similar circumstances, been cut by the surgeon, but surgical intervention in respect of this particular malady is at best but a *pis aller*. It is attended by a great and unavoidable risk to life, and its results are by no means uniformly satisfactory. Moreover, it is based on the assumption that the disease owes its existence to a condition of hyperactivity on the part of the thyroid gland, whereas in quite a number of recorded cases the administration of thyroid extract has appeared to be productive of benefit. The difficulty of discovering a truly curative treatment is enhanced by the fact that the disease is one which not unfrequently undergoes spontaneous subsidence, and this amelioration is very apt to be placed to the credit of the agent last employed. The treatment, such as it is, is purely symptomatic, and is directed rather to the alleviation of the more prominent symptoms than to the underlying cause. If it be due to excessive activity of the thyroid gland, which is far from proved, we still have to ask ourselves what morbid process underlies this exaggeration of function. The only safe plan under existing circumstances would appear to be to change the habits of life and the environment of the sufferer. Above all we must be careful not to interfere with any tendency to spontaneous recovery, and with that object in view no drug should be pushed to an injurious extent and, indeed, not pushed at all unless it appears to be promoting recovery. It may well be that the group of symptoms included under this designation are dependent on more than one morbid influence, and if this be so we shall not attain any great measure of success in treatment until further light has been thrown on the intimate pathology of what must be admitted to be still a highly complex and obscure affection.

#### Moderate Drinking and Total Abstinence.

ALTHOUGH comparatively few people practise total abstinence, the proportion of intelligent persons who, theoretically at any rate, admit that total abstinence is compatible not only with good health, but with the reasonable enjoyment of life, is yearly increasing. Now and again someone takes up the cudgels in defence of the moderate drinkers with more or less success. Some years since it was the late Dr. Mortimer Granville, whose trenchant letters to *The Times* excited a good deal of interest and discussion; more recently Sir Dyce Duckworth has publicly endorsed the view that the lives of truly moderate drinkers of alcohol are, on the whole, better and more useful than those of abstainers. When, however, we come to inquire into the amount of alcohol permitted to those who claim to figure in the list of really moderate drinkers it must occur to everyone that the difference between them and total abstainers is not very great. Even the traditional one ounce and a half of alcohol seems to err on the side of what we may call moderate excess. Then again the fact that moderate drinkers lead useful lives does not preclude the belief that they would lead even more useful lives if they abstained altogether. Moderate drinkers are presumably people gifted with sufficient self-control to hold their passions and appetites in leash, and, since self-control is the standard of a man's moral elevation, the greater the restraint the greater the merit and the greater the benefit, not only to the individual but to the community at large. Many total abstainers abstain simply because they cannot tolerate alcohol even in moderate doses, and are *pro tanto* of an inferior physical stamina. Logically it hardly admits of a doubt that if those who could tolerate it did not avail themselves of the privilege their conduct would be to their own advantage, besides setting an excellent example to their weaker fellows.

#### The Succession Value of Public Appointments.

It is hardly a wise attitude on the part of a medical man to regard his tenure of a public appointment as a marketable asset. That view has recently been brought home in a somewhat unpleasant fashion to a gentleman who has recently resigned the post of Medical Officer and Public Vaccinator to the Epping Board of Guardians. He wrote recently to the Board stating that he had sold his practice and hoped that the purchaser might become his successor in his public posts which had been included in the sale. To write a letter of that kind was indiscreet, but the gentleman in question multiplied the indiscretion by appearing before the Board and stating that if the purchaser of his practice were not elected he himself would lose £120 by the transaction. He added that he had secured the interest of the Vice-Chairman, and hoped that the Board would elect his successor in the practice, as he wished to avoid losing the money. It is not surprising that this extraordinary application

was denounced by the Board as an attempt to reduce a public office to the rank of a marketable commodity. Another candidate was forthwith elected. Were vested interest of the kind contemplated by this singularly ingenuous vendor of a medical practice to be permitted the position would quickly become intolerable.

#### Motor Cars for Consumptives.

ANOTHER argument in favour of the much-favoured automobile has arrived. It is pleasing to know that the fashionable car is now to serve a useful medical purpose. Its recent contributions to surgery, as all know, have not been few. Dr. Dawson Turner, Vice-President of the Scottish Automobile Club, believes the motor car will prove a valuable means of affording out-door treatment for the consumptive. Every sanatorium is to have its automobile, and a daily run is to become a part of routine treatment. The pace advised is "fully up to the legal limit." Along with a feeling of marked exhilaration, an increased appetite, and improved sleep, there is a "heightened healthy glow, which after a few days' treatment, tends to become permanent." We recently had occasion to rejoice in the munificent gift of £100,000 to the Mount Vernon Hospital for Consumption, and doubtless before long we shall have the pleasure of chronicling the presentation of automobiles to this and all other institutions aiming at the restoration of the phthisical sick. Will philanthropists and millionaires please note? A word to the rich should be enough!

#### Is Plum Pudding Digestible?

THE genius of our forefathers worked out that king of all dishes—the English plum pudding. Their wisdom, however, did not end with toothsome-ness, for they made a food that, being both rich and savoury, was nevertheless not rankly indigestible. Truth to say, and speaking with a full sense of responsibility that lies in the utterances of a medical journal upon so important a matter, plum pudding is not to be denied save by the weakest of stomachs. The mere fact of the prolonged boiling that is part and parcel of the solemn rites of the kitchen, carries the pudding far on the road to the digestion that is the ultimate goal and end of its existence. Christmas pudding, in a word, is digestible enough to suit all mankind, except, perhaps, in the extremes of infancy and old age. But—and here comes the saving clause—it must ever be borne in mind that the harmfulness of good cheer lies more in quantity than in quality. Where one fair slice of speckled pudding will bring a sense of comfort and goodwill to all men, two will be likely to upset the harmony of the inner and outer man, while three will throw out a pressing invitation to the fiends of sleeplessness and indigestion and goutiness and other ills. To our mind little harm, we repeat, is done by good, sound, solid, well-made, well-boiled, and well-served English plum pudding. When the king of dishes is thrust away pell-mell on top of a vast medley of meats and drinks, then there

can be little wonder if Nature resents the outrage on her arrangements as Minister of the Interior of mankind. Happily a little over-eating once in a twelvemonth is not likely to do any lasting harm—not even when the surfeit is of plum-pudding.

#### The Cold Tub.

THE *Yorkshire Daily Post* has its attention called by a correspondent to what the editor facetiously calls that "hardy annual," the cold tub. The writer was a thin, weakly man, it appears, with one foot in the grave, when he married and began his morning plunge: now he is hale and hearty. What does this mean? If the morning dip can bring strength to the weakling then it were simpler to "throw physic to the dogs," and attend to the bathroom arrangements instead. Cold water, however, is not fitted for everyone. In its right place it is a magnificent tonic and bracer of the system, but it is only fit for the robust and for persons of active habits and healthy arteries. Cold tubs should be allowed neither to babes nor to old persons. Even in the case of robust folk it is perhaps advisable to take the chill off the bath in the depth of winter. It is all very well for hardened mortals to break the ice for a morning dip, but even for them the time must come when their frames will demand a sybaritish dash of warm water to temper the rigours of their watery exercise. It is not a little remarkable how many town dwellers keep up the custom of the cold bath, in spite of the lack of exercise that only too often falls to their lot. For the man in chambers to lave himself in a fireless bedroom with half-frozen water in a sponge bath is a very different thing from getting into a plunge bath in a well-warmed bathroom. Finally, the cold bath is most excellent for those who thrive on it; individual experience is the test.

#### The "Nudity" Cure.

WHILE medical science is painfully and laboriously winning its way to the goal of exactitude, a large field of the partly-known and of the unknown lies in possession of quacks. So far as the world at large is concerned there appears to be no method of so-called "cure" too grotesque, too revolting, too meretricious to be swallowed—and paid for—in wholesale quantities by the vulgar. One pretender advertises to cure rheumatism by means of a magic ring, and straightway he vends his fraudulent wares by the bushel. Another puffs a "cure all" in the shape of a worthless belt, and money forthwith pours into his coffers, while the highly-qualified University graduate works hard for a bare living. At any rate the qualified man has the satisfaction of knowing that the poverty is that of an honourable gentleman. The "nudity cure" is a parasitic craze of Austrian origin. It is described as a method whereby neurasthenic patients are exposed to air and sun in a costume composed of "a hat and short trunks." Thickets are carefully arranged so as to separate the sexes, and the treatment is "completed" by a combination of baths, massage, gymnastics, games, and

vegetarianism. The scheme appears to be a gratuitously eccentric variation of the open-air treatment, which has been tricked out in the fantastic "nudity" fashion on strictly commercial lines. The attempt to attach a curative element to the fig-leaf garb of our first parents in the garden of Eden is well worthy of the business-like ingenuity of the latter-day irregular medical practitioner.

#### Railway Tube Ventilation.

THE Central London "tube" railway does not appear to have hitherto risen to the necessity of amending its ways in the matter of ventilation. In one or two of the stations, it is true, there has been some slight improvement attested by the free draught blowing down the "lift" shaft and along its underground approaches. That happy result seems to have been secured simply and solely by opening the outlets and inlets provided in the roof of the shaft. In other stations, however, the hermetic sealing of shafts appears to be the guiding principle of the officials in charge. To take a special instance, that of the Chancery Lane Station. The lift, especially in the morning, is often hot, stuffy, and reeking with the unmistakable fumes of bad ventilation. To make things worse the floor has often been recently washed and the air is heavy with stale tobacco. Long since we pointed out that by knocking out the small panes at the top of the entrance and exit doors the lift could be thoroughly ventilated. It seems clear that the shaft itself has no adequate air inlets, or at any rate if they are present they are not kept open. The Central London Railway authorities will do well to send an official up and down their line to see that all the ventilating appliances are kept in proper working order. It would be a pity were the popularity of this line to be spoilt by inattention to so important a detail as that of ventilation. Other towns of the United Kingdom, where tubes are in contemplation, will do well to bear the Metropolitan experiences in mind.

#### The Prevention of Fogs.

THE recent long spell of fog has resulted in much correspondence in the daily press, and many suggestions have been made with a view to the removal of this nuisance to which Londoners are subjected. The matter does not concern the Metropolis alone, as some people appear to think, but all manufacturing towns in the country. We have seen fogs in Manchester, Liverpool, and Birmingham, for instance, which would run a dead heat with the "London peculiar." The subject was recently discussed at a meeting of the Coal Smoke Abatement Society, and the resolution was passed "that, in the opinion of this meeting, the pollution of air is injurious to public health and vitality, destructive to works of art and to vegetation, and directly demoralising to the inhabitants of a great city." The meeting pledged itself to do its utmost to prevent the smoke nuisance, and thereby reduce the effect of fog. They, however, omitted to mention the means by which they pro-

posed to produce this effect. As we all know, fog, in the form of condensed aqueous vapour, cannot be prevented, but if smoke could be avoided the fogs would be comparatively helpless. The chief characteristic of carbon, which is the principal constituent of soot, is its capability of absorbing and retaining injurious substances, such as sulphuric acid, sulphurated hydrogen and tar. The last substance causes much damage to works of art by coating them with a thick black deposit. That the other substances also cause destruction has been proved by examination of the deposits on St. Paul's Cathedral, where much damage was done by a substance formed by sulphuric acid corroding the Portland stone. We sincerely hope that something will come of this meeting, but many of the remedies suggested in the daily Press are, to say the least, impracticable, and many absurd. In one paper a correspondent suggested driving the fog away from the chief streets by means of motor steam fans. We do not think that an army of motor-cars driven through the streets of London would tend to improve the present congestion of traffic, even if they did succeed in driving away a certain amount of fog. Moreover, if the fog is driven from one place it is simply displaced, not destroyed. The only reasonable plan is to take measures to prevent the production of smoke.

#### The Mentone Manifesto.

In reply to many inquiries by medical men and others, we think it well to republish, *verbatim*, the so-called "Mentone Manifesto," relative to the non-reception there of "consumptives." "For some years past the *clientele* of Mentone has undergone a complete change. Visitors suffering from consumption have become extremely rare. Habitual visitors are well aware of this fact, but as the contrary opinion appears to be entertained in other quarters, the under-mentioned hotels beg to announce that they do not receive consumptives:—Alexandra, Ambassadeurs, Anglais, Angleterre, Beau Rivage, Bellevue, Colonies, Europe and Terminus, Grand Hotel, Iles Britanniques, Italie, Littoral, Louvre, Malte, Menton, Mont Fleuri, National, Orient, Parc, Prince de Galles, Riviera Palace, Royal Westminster, Russie and Allemagne, Santa Maria, Turin Beau-Sejour, Venise, Victoria and Princes, Wagner, Windsor Palace." It will be seen at once that this document is not, as some have erroneously supposed, a Resolution or Ordinance of the Municipality of Mentone, autocratically forbidding any special class of invalids to benefit by a long or short sojourn at their especially favoured and very beautiful town. It is simply a notification to physicians and others concerned that "consumptives" are not considered desirable visitors by the twenty-nine principal hotels named in their "Bradshaw" advertisements. There are, however, other comfortable hotels, boarding establishments, and apartment-houses at Mentone which, doubtless, yet welcome all guests, even if of "consumptive" tendencies. There is also a good and pleasantly situated "Sanatorium," near Mentone, so that phthisical per-

sons who contemplate a visit to Mentone need be under no apprehension on the score of accommodation.

### The Detection of Antimony in Presence of Arsenic.

THE quantitative estimation of antimony in presence of a comparatively large proportion of arsenic has hitherto been regarded as one of the most difficult feats in analytical chemistry. Dr. Denigès, of Paris, claims to have discovered a means of detecting the thousandth part of a milligramme of antimony in presence of five hundred times its volume of an arsenical compound, and he recently described his *modus operandi* before the Academy of Sciences. The substance to be analysed is dissolved in strong hydrochloric acid, and placed in a platinum crucible. Into this a piece of tinfoil is placed, reaching to the bottom of the crucible, and on this is formed a brown stain of antimony. A confirmatory test consists in watching the behaviour of the same hydrochloric solution under the microscope in contact with a solution containing one gramme of potassium iodide and three grammes of chloride of cesium in ten grammes of water. If antimony be present there is a formation of hexagonal lamellæ of the yellow double iodide of antimony and cesium.

### Jews and Drunkenness.

It is often said that we are a drunken people. There is certainly too much evidence of the truth of this charge to warrant any disclaimer. Dr. Archdall Reid, in his work on "Alcoholism," claims that Jews under every condition of life are invariably sober. He thinks that this is not because they resist temptation, for as a race they are not particularly given to austerity, but because deep indulgence is disagreeable to them. We have made inquiries respecting the drinking habits of the Jewish people in the East End of London. So far the evidence we have been able to obtain quite substantiates Dr. Reid's statement. One medical man whose practice is made up in great part of Jews, informs us that during the last ten years he has only once met with a drunken Jew, and in that case the Jew as regards his general manner of life and attitude to the Mosaic ritual was a Gentile. The matter is one of much interest and great practical importance, and worthy the attention of medical men practising in Jewish quarters.

### Post-Rectal Dermoids.

DERMOID tumours wherever found have an interest which is less generally extended to other forms of tumour. Not alone is the locality of great interest, especially when they are found in places which rarely accommodate them, but various specimens present many striking differences in constitution. The difficulty in drawing a hard and fast line between dermoids and teratomata is well illustrated by a case of post-rectal dermoid tumour recorded in the "Quarterly

Medical Journal for Yorkshire and Adjoining Counties" for November by Dr. Sinclair White. The short account is illustrated with pictures showing the tumour in the coccygeal region of a child, aged three years, and the microscopical appearances of a section showing true bone structure. The tumour is described as containing sebaceous material, long grey hairs, and two perfect incisor teeth embedded in the mass of dense bone.

### Academical Costume.

THE Council of the Royal College of Surgeons, Ireland, has recently adopted a distinctive gown and cap which may be worn by the Fellows of the College. The Council has issued the following resolution on the subject:—"The general body of the Fellows are authorised to wear a black stuff Master of Arts gown, faced with a St. Patrick's blue Irish poplin border, five inches in width, narrowing round the collar behind, and extending to each end of the gown in front. Inside of the blue poplin there shall be a crimson Irish poplin lining, five inches in width, and of similar extent as the blue. A black velvet college cap, with St. Patrick's blue and crimson tassel. This gown and cap may be worn at all public functions, college ceremonials, state and civic public meetings, and on all occasions when academical costume is worn by the general body of the Fellows of the Royal Colleges of Surgeons of England and Edinburgh."

### PERSONAL.

MR. W. HUNTER, M.B., C.M.Aberd., has been appointed Government Bacteriologist to the Colony of Hong Kong.

MR. GEORGE LENTHAL CHEATLE, C.B., F.R.C.S., has been appointed Surgeon to the Italian Hospital, Queen's Square, W.C.

DR. AMBROSE, Birmingham, Professor of Anatomy in the Catholic University School of Medicine, has been appointed an Examiner in Anatomy to the University of Cambridge.

A COMPLIMENTARY dinner was given to Dr. F. J. V. Hall, of Hay Mills, on the 15th inst., to celebrate his successful refutation of the charge made against him in the Solihull County Court, to which we alluded last week.

DR. GLYNN, of Liverpool, on terminating his connection with the Liverpool Infirmary, has been presented with his portrait in oils, painted by Mr. E. E. Morrison, and was entertained by his friends at a dinner given in his honour at the Adelphi Hotel.

H.R.H. THE PRINCE OF WALES has been unanimously nominated Chancellor of the University of Wales. H.R.H. has definitely consented to become President of the National Association for the Prevention of Consumption and other forms of Tuberculosis.

DR. E. WALSH was last week presented with a gold watch and chain and an illuminated address by some of the inhabitants of Abercarn and the officials of the Prince of Wales Colliery (of which he was Assistant Medical Officer) on his leaving the neighbourhood.

MR. DEANESLY and Mr. A. H. W. Hunt were last week elected Honorary Surgeons to the Wolverhampton and Staffordshire General Hospital. Mr. Deanesly was formerly House Surgeon at University College Hospital, London, and Mr. Hunt House Surgeon at Westminster Hospital.

THE following gentlemen have been appointed Assistant Medical Officers in the hospitals of the Metropolitan Asylums Board: Mr. D. Brewer, M.B.C.S. Eng., L.R.C.P.Lond; Mr. C. De P. D'Amico, M.D.Malta, M.B.C.S.Eng., L.R.C.P.Lond; Mr. C. C. Lall, M.B., B.Ch.Ed.; Mr. R. Niven, M.B., B.Ch.Glasg., D.P.H. Camb.; and Mr. A. E. Spencer, M.B., M.R.C.S., L.R.C.P.

## Manchester.

[FROM OUR OWN CORRESPONDENT.]

### THE LIGHT TREATMENT OF DISEASE AT THE CLINICAL SOCIETY.

THIS society, which is in flourishing condition this year, under the presidency of Mr. Herbert Lund, held its December meeting at the Manchester and Salford Hospital for the Diseases of the Skin instead of in its own rooms at the Palatine Hotel. This was done by the kind permission of the Hospital Committee, in order that the members of the society might have, from Dr. Brooke, a demonstration of the Light Treatment of Skin Disease. It was explained that the modern treatment of lupus and other skin diseases by means of light is based upon the influence which sunlight has been proved to have upon the life and growth of certain micro-organisms by various experiments made upon cultures in the laboratory. In order to ascertain the effect of sunlight upon organisms living within the tissues, lupus was selected for experiment on account of the superficial position of the lesions it produces. The next step was to concentrate the rays of sunlight upon small areas of diseased skin by means of lenses. These were made of large size (those shown appeared to be 8 or 10 inches in diameter) and hollow, so as to contain water with various pigments in solution. The actinic rays being the valuable ones from a therapeutic point of view, and the heat rays at the other end of the spectrum being apt, when concentrated, to burn the patient, the lenses are filled with blue solutions which cut off the heat rays and let the actinic arcs pass through. These lenses of sunshine were always and everywhere available and would appear to answer all requirements. The Finzen lamp was devised simply in order to provide an artificial substitute for direct concentrated sunshine. As seen at the Manchester and Salford Skin Hospital the apparatus is briefly as follows: A dynamo connects the town electrical supply into a current of 65 volts, and 70 or more amperes which works an arc lamp many times as powerful as those employed for lighting. Round this are arranged radially several telescope-like tubes containing lenses which concentrate the light on to a surface about an inch in diameter. The lenses are made of rock crystal instead of glass to favour the passage of active rays. Cooling is managed by allowing a stream of cold water to flow constantly through a portion of the tube. As the red blood in the tissues protects the bacilli within from actinic rays, just as the photographer's red lamp shade protects his sensitive plates from the same rays. Something has to be done to keep the blood out of that portion of the skin which is under treatment. This is managed

by a nurse, who presses against the patient's skin during the fifty minutes or so of exposure to the light, a small instrument, consisting of two layers of crystal between which a stream of water flows constantly to prevent heating. The pressure produces a temporary anæmia in the part, and exposes the bacilli beneath to the full action of the light. The Lartet lamp is a simpler arrangement. One arc lamp is used for each patient, whose skin is close to it, pressed, for anæmia, against a transparent cooler, like a child's nose against a window pane. There was an army of patients on show, many of them with photographs, which showed their condition "before and after" treatment in a way which speaks well for the value of the method. Röntgen ray instruments and high frequency apparatus were also on view.

## Correspondence.

[We do not hold ourselves responsible for the opinions of our correspondents.]

### SUGGESTIONS FOR THE IMPROVEMENT OF THE HUMAN RACE.

To the Editor of THE MEDICAL PRESS AND CIRCULARS.

SIR,—With reference to your criticisms, p. 582 of your issue for the 27th last month, on Mr. Galton's lecture, permit me the following suggestions:—Wealthy persons might leave sums in their wills in the hands of trustees, who should be medical men, experts on heredity, and men of business and experience in human nature. Their duties would be the enabling, not bribing, any extra fit persons to marry, and if possible intermarry, who are at present delayed or prevented from doing so by prudential considerations. By fit persons I mean the socially, emotionally, or morally fit, and those intellectually fit—not merely athletes. What is required is not so much artificial selection, but the restoration of natural selection—the natural selection of the socially and truly fit. But where are these persons, fit in various ways, to be found? I imagine that persons accepted and retained in certain Government services must have satisfied a certain standard as to character, and undergone examination of intellectual and physical qualifications. I see that the Postmaster-General has given marriage gratuities to post office employees after a certain number of years' service, and thus somewhat compensated them for the loss of pension which their retirement for marriage involves. Now, the obstacle to the marriage of the fit is that they do not wish to have a larger family than they can honourably maintain, and they like to make sure before marriage that their offspring shall have at least as good an education as they have had themselves. Nowadays the fit are in danger of being swamped. They are handicapped by rates for the sustenance of the rest and the preservation of the unfit tribes from their natural elimination. It is necessary to counteract this reversed natural selection by removing certain financial obstacles which unfortunately chiefly operate in the case of the socially fit. Future maintenance of each child which they shall have successfully reared to its fifth year, a good education and start in life should be guaranteed to them. This form of encouragement would appeal chiefly to the true parental instincts of the socially fit, and would permit their unions to be reasonably productive, but not teach them to regard their families from a mercantile point of view, nor bring about an increase so rapid that quality might be sacrificed to quantity. As the provision would be made for their offspring, and not directly for themselves, it would not be specially sought for by selfish and socially unfit persons. However, it would be for the trustees to find out extra fit persons who were already thinking of marriage, not for athletes to exhibit themselves, nor would there be anything like public competition for prize marriage portions.

I am, Sir, yours truly,  
CHARLES G. STUART-MENTEATH.

23, Upper Bedford Place, W.C.,  
Dec. 18th, 1901.

## PREMATURE BURIAL.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Your editorial comment seems to invite further observation.

The "weak logic" of my letter appears to consist in the assumption that human fallibility, which is generally undisputed, extends to the diagnosis of life and death. That non-professional persons may mistake in this respect is fully admitted and insisted on by the late Dr. Swaine Taylor in his "Principles and Practice of Medical Jurisprudence," but the writer thinks that "mistakes of this kind are not likely to be made by medical men." Even if this were the fact, what is the value of the protection if a medical man gives the death-certificate without seeing the supposed dead, as he is entitled by law to do, and generally does? I may add that the writer quotes several cases of premature entombment or burial which he does not seem to dispute. I think he underrates the danger, but he says enough to convince the reader that it is a very real one; as it must be, if the non-professional man is not to be trusted to distinguish cases of real from apparent death, and the professional man does not attempt to do so.

You say "that no instance of premature burial has been proved by evidence that would carry conviction to the minds of a legal tribunal." You do not quote any case in which evidence of live burial has been refused or exceptionally treated, and I cannot for a moment imagine that a judge of the High Court would be more strict in requiring evidence of an alleged live burial than of an alleged burglary. I may remark further that a question of live burial is a question of fact and not of law, and, moreover, a legal tribunal is not a calculating machine, but consists of one or more persons of like passions with the rest of mankind. A tribunal composed of persons like-minded with the late Sir B. W. Richardson would have no difficulty in accepting evidence of cases of premature burial. Moreover, in Tebb and Vollum's "Premature Burial," pp. 55-56, there is a quotation from the *British Medical Journal* of December 8th, 1877, referring to a case before the Appeal Court of Naples, in which the Court sentenced a doctor and a mayor to three months' imprisonment for involuntary manslaughter in authorising a premature interment.

Let me conclude by asking three questions:—

1. We read occasionally of medical errors in diagnosis of disease. Are we to reject such statements as idle tales? If not, why should we suppose doctors to be incapable of making erroneous diagnosis of death?

2. If the fear of premature burial is groundless, why have so many eminent men expressed an opinion that the danger is a real one?

3. Why do we seldom or never see any contradiction of the statements of premature burial which are from time to time published in the Press?

I am, yours faithfully,

H. N. MOZLEY, M.A.,

Barrister, of Lincoln's Inn.

East View, Murray Road,  
Northwood, Middlesex.  
December 19th, 1901.

## FISH AND JAPANESE LEPERS IN HAWAII.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—As to the question of leprosy fish diet and the Japanese in Hawaii, Dr. M. Goto, present chief of the Sanitary Bureau of Tokio, formerly the Japanese expert on leprosy in Hawaii under King Kalakua's Government, wrote me from Molokai July 8th, 1894, as follows (I translate from the Japanese):—"In 28,072 Japanese immigrants to these islands (critically examined for leprosy before their departure from their own land) there were five men who became leprosy long after their arrival; four of these were sent back to Japan. Besides, two others, who had become suspects, were also sent back. Although it is claimed that the cause of leprosy is fish eating, I never discovered such a reason. It is quite true that Hawaiian natives like very much to eat fish, and that Japanese also like it. But a good proof that leprosy is not dependent on fish

diet (he means *per se*) is to be found in the fact that the Japanese in Hawaii are so little subject to the disease. I came to this island in March, 1893, on the invitation of the Hawaiian Government."

In his book "Nambio-fi-riyo" ("Home Treatment of Leprosy"), Tokio, 1882, which I translated into English, Dr. Goto says that he is not a believer in contagion, nor heredity of leprosy, thus catering to popular opinion. He mentions as causes: living in swamps, eating of whale flesh and maguro or tunny-fish, horse and cat flesh, snakes, &c. "These act as poison (he says), in fact leprosy is always the result of some kind of poisoning. This extraneous poison acts as an irritant on the hidden principle of leprosy in the system."

Dr. Goto had lived in Hawaii hardly long enough to determine this question of influence of native fish diet on the Japanese immigrant, nor had his countrymen been resident there (presuming them to be perfectly free of Japanese germs of the disease) long enough to have developed the native germs. The first Japanese immigrants only went to Hawaii February 8th, 1885. The very fact that five of these had already in eight years become recognised lepers, and two others suspects, is proof that Hawaiian cause and effect, whatever it is, was already operating, although the disease was not yet epidemic among them. For myself, I believe that the edible fish of Hawaiian waters are widely contaminated with leper germs (*spores*, not bacilli) through the insects (mosquitoes) of the islands.

I am, Sir, yours truly,

ALBERT S. ASHMEAD, M.D.

New York, December 12th, 1901.

## Literature.

## DE MERIC ON SYPHILIS AND OTHER VENEREAL DISEASES. (a)

This is a practical work by an evidently practical man who does not attempt to go over the whole ground of the manifold lesions that have, rightly or wrongly, been ascribed to tertiary syphilis, but who gives us hints and treatment of his own knowledge and experience in simple and unaffected language.

There is a very interesting chapter on serum-therapy in regard to the prophylaxis of syphilis. What is required, the author observes, is a large central hospital where prostitutes could be taken as in-patients and where they would not only undergo the necessary treatment for their disease, but would also be made to feel that they were not looked upon as the scum of the earth; for without kindness, it would be impossible to get these women to enter such a hospital. "Persons are taken up for begging, therefore women should be taken up for annoying with solicitation, which after all is but another form of begging; and let it be remembered that the mendicity officer does not require the evidence of the person from whom the alms were asked, so a detective should not require the evidence of the man annoyed by the persistence of the prostitute.

The author treats soft sores with fuming nitric acid, warm lot. ac. carbol. 1 in 80, and then "black wash." Syphilis is treated by hyd. protoiodide gr. ʒ to gr. j, with ext. gent. and ext. opii, so that the patient can always have the remedy in his pocket. Pot. iod. is considered as a kind of scavenger to remove the refuse of the disease. The so-called syphilitic fever, coming on a few days before the rash, the author would prefer to call syphilitic migraine. Gonorrhoea is treated by iodoform and eucalyptus bougies and red lotion or permanganate of zinc, gr. ʒ ad. ʒj or weak lot. carbolic 1 in 200. For women, lotion arg. nit. gr. 2 8 ad. ʒj is preferred. Copaiba, cubebs, &c., are reserved for gleet; when the bladder is also washed out with strong boracic lotion. The author thinks that Diday's urethrorrhoea is a mild form of gonorrhoea, and that the gonococcus is present probably in a sporal form, and in a form or shape that

(a) "Syphilis and other Venereal Diseases." By H. de Méric, M.R.C.S. Surgeon to the French Hospital, London, &c., &c. London: Baillière, Tindall and Cox, 8, Henrietta Street, Strand. 1901. Price 5s. net.

has not been discovered. This discharge, if neglected and irritated, shows the presence of the gonococcus. On the whole, we are much impressed with the views and treatment enunciated, and many a general practitioner will be glad to possess so practical a monograph on these common but often intractable diseases.

#### MORRIS ON SURGICAL DISEASES OF THE KIDNEY. (a)

UNQUESTIONABLY Mr. Henry Morris's new work on the surgical diseases of the kidney and ureter deserves to be placed in the very foremost rank. We shall refer in this notice to the first volume only, leaving the second for consideration in a subsequent issue; the value and importance of Mr. Morris's great work cannot be too early known. It is not merely a second edition of his manual on the "Surgical Diseases of the Kidney," which appeared many years ago. The work of others, up to date, is fully recognised, at the same time the author's extensive experience is most judiciously used and put forward with the greatest fairness before the reader. The work, considering its size, can scarcely be said to be profusely illustrated. The illustrations are, however, of the highest order; as specimens of the artists' and engravers' arts they deserve careful study. The points which each one is intended to illustrate are readily apparent, and very little description requires to be added. They form a delightful contrast to the style which has become unfortunately popular in works which deal with subjects in which museum specimens necessarily figure largely. We refer to the reproductions of photographs which in too many cases are absolutely unintelligible to anyone unfamiliar with the specimens themselves. We have thus briefly referred to the illustrations in Mr. Morris's book because we feel that well-executed, carefully chosen illustrations are evidence of more than the publishers' liberality. They indicate the author's true love of, and pride in, his subject, almost as much as can the letterpress.

It is quite impossible to refer to more than a very few of the points which have struck us in reading this book. Many will be pleased to see that such an authority unhesitatingly states that the kidney, even when normal, cannot always be palpated. Again, that urinary extravasation need only be feared after wounds of the kidney when its pelvis is implicated. Athol Johnston is considered to have been right when he long ago pointed out that painful and tympanitic abdominal distension following injuries to the kidneys is not necessarily due to peritonitis. The importance of conservative treatment of wounds of the kidneys, unless life be threatened by hæmorrhage or suppuration, is strongly advocated; yet when the bladder becomes distended with blood clots which cannot be satisfactorily removed by the evacuator, cystotomy should be performed; and in this connection the remark is made, "Miraculous recoveries must not make us lose sight of general principles, nor extraordinary cures cause us to forget ordinary dangers."

The chapter on "Urinary Fever" is a most valuable one. House surgeons and others are warned against exploring the bladder hastily and recklessly. "It is a light matter to them to introduce a sound, but it may turn out a serious one to the patient." Let the patient be first prepared as for "any other surgical operation."

Mr. Morris has not found the phenendoscope of as much assistance in diagnosis as have some of the French writers. He uses the term "large polycystic kidney," rather than "cystic disease," and he regards the congenital cystic kidney of the fetus and newborn as essentially the same disease as the polycystic kidney of the adult, and both as being due to some form of obstruction, congenital, inflammatory, traumatic, &c., in the kidney, ureter, or urethra. Mr. Morris gives no support to the use of the urethral catheter in the treatment of cases of pyo-nephrosis. He

describes it as impossible to use in many cases, and very dangerous in others. Attention is called to the great importance of recognising the sign of increased frequency of micturition, both at night and during the day, in cases of renal tuberculosis; it is frequently found quite apart from ulceration of the bladder. The purely pathological side of the subject has been treated with excellent discretion by the author. Not a single illustration of the microscopical appearances of any specimen is given, and for this we think the author is to be commended. The difficulties of this part of the subject have nevertheless received careful treatment. Considerable stress is laid on the importance of recent varicocele as a sign of value in renal cases. The chapter on the Regional Anatomy of the Kidney is concise, nothing of any practical importance is omitted, and everything included is important to both the physician and surgeon. We think an index at the end of the first volume would be an improvement. There are, however, very few points of importance to which reasonable objection can be taken throughout the work, but as suggestions for future editions we would call attention to the fact that Holt's dilator is referred to in several places, but we are not given Mr. Morris's opinion of its value. We can scarcely think he intends that much stress is to be laid on "the family history of tubercle" in trying to arrive at a diagnosis. It is a point on which relatives are much inclined to lay great emphasis, and frequently the practitioner allows himself to be swayed too much by it. Many question the usefulness of the "hot sponge test" as an aid to the diagnosis of spinal caries. "Ehrlich's test" has disappointed so many observers that we believe comparatively few place much reliance on it. In uncomplicated shot wounds of the kidney the percentage mortality is put down as 85; this is evidently a misprint, it ought to be 25. We would hesitate to mention these points, which do not really concern the subject proper of the book, were it not that they will serve to show how very little we have been able to find after, careful reading, to which we can take exception.

The arrangement of the book is admirable, the descriptions are lucid, the details of differential diagnoses thoroughly practical, the illustrations, as we have already said, are among the finest of their class we have seen, and the treatment recommended is evidently based on opinions formed in no hasty manner, but as the result of calm and "judicial" investigation. Over one thousand authorities are cited and quoted, some of them many times, through the two volumes.

#### RABAGLIATI'S APHORISMS. (a)

THE title of this somewhat bulky volume is calculated to excite curiosity by reason of its old-world flavour. After dipping into the motley array of disjointed reflections, but few whereof can justly be called aphorisms, one instinctively turns to the preface in order to ascertain as far as may be what object the author had in his mind in launching his work. He defines these observations as themselves an introduction or preface to the theory and art of medicine, the position of which, he says, is depressing. If intending students were constrained to master this volume before going further the ranks of the profession would be thinned to an undesirable extent. The author premises that what we require is less any addition to the number of scientific facts than due consideration of the bearings of facts and observations already at our disposal. We want, he says, a philosophy rather than a science, in fact, his ideal is "a true science of medicine and surgery founded on a sound philosophy." We then dejectedly returned to the text in order to try and grasp the meaning of these phrases, but we are immediately confronted with the frequent recurrence of such words as kakositeism, polysiteism, pollakisiteism, &c., the meaning whereof we must leave our readers to find out without the aid of a dictionary, inasmuch as no dictionary con-

(a) "Surgical Diseases of the Kidney and Ureter, including Injuries, Malformations, and Mislacements." By Henry Morris, M.A., M.B.Lond., F.R.C.S., Senior Surgeon to the Middlesex Hospital, &c. In two volumes, large demy 8vo. Pp. 1,352. With two coloured plates and upwards of 200 illustrations. London: Cassell and Co. 1901.

(a) "Aphorisms, Definitions, Reflections, and Paradoxes." By A. Rabagliati, M.A., M.D., F.R.C.S. Ed., Honorary Gynaecologist, late Senior Honorary Surgeon, Bradford Royal Infirmary. London: Baillière, Tindall and Cox. 1901. Price 7s. 6d.

tains them. We gather that the author conceives the chief cause of disease to be improper feeding, no doubt a very important factor, the effects of which are intensified and reinforced by improper and unsuitable aëration. There is nothing very novel about this, and in so far as the author gives his thesis a novel bearing we disagree with him. What the author gives us as aphorisms are for the most part mere assertions, but having, as he imagines, established their validity by solemn statement, he argues thereon *à perte de vue*.

There is a good deal of sound observation and practical common-sense in much that the author advances, but really he might have given us the outcome of his extensive experience in some less disjointed and repellent form. We have laboured in vain to follow the vagaries of his restless intelligence, and we can only hope that the literary banquet may prove more digestible to others than we ourselves have found it.

#### "PLASMON COOKERY BOOK." (a)

ONE of the principal difficulties attending the introduction of a new alimentary substance is to get the public to understand how it should be employed. Simple as may be the requirements, it is absolutely necessary to go into details, and to explain the various ways in which it can be turned to account in the alimentation of the sick and of those for whom the food is intended. We commend the enterprise which has stimulated the Plasmon Company to compile this little book of directions. The services of professional cooks and cookery teachers were enlisted and prizes were given to those whose achievements commended themselves to the jury at the Twelfth Universal Cookery and Food Exhibition. The recipes are very numerous; indeed, there is scarcely an article of food which cannot advantageously be enriched by admixture with this readily soluble and unaltered albumen. Viewed merely as a cookery book, this little compilation deserves the close attention of housekeepers and cooks, and if the directions are intelligently followed a sumptuous repast *à la Plasmon* can be placed on the table. Plasmon, it may be observed, has no taste or distinctive odour of its own, so that it lends itself to the most varied combinations, thus avoiding the monotony which has hitherto been the bane of the invalid dietary. The addition of Plasmon entails no strain on the digestive powers, since it is claimed to be unaltered soluble albumen susceptible of assimilation in the economy with a minimum of organic change.

#### CARTER ON THE ELEMENTS OF PRACTICAL MEDICINE. (b)

THIS primer evidently maintains its not undeserved popularity with students. It does not pretend to give more than the elements of practical medicine, and these are set forth in a clear and concise manner. There are, however, several points in which the author does not seem to have made the best of his opportunity for revision. This is especially applicable to treatment, which has always been a weak point since the days when we laboriously committed its contents to memory. In actinomycosis, for instance, the curative properties of iodide of potassium are not even referred to, while in alopecia areata the only therapeutical advice given is the application of "a reliable antiseptic lotion," which gives a very feeble idea of actual requirements. The treatment of lupus is even more inadequate. It would be easy to multiply instances of this kind, but an equally serious lapsus is the omission to refer even in a brief way to the *filaria sanguinis hominis*, acromegaly, syringomyelia, and sundry other rare but interesting affections of which no student ought to be altogether ignorant. Recent discoveries on the ætiology of certain forms of pernicious anæmia and its curative treatment find no mention, in fact, the chapter is much the same as it was

ten or twenty years ago. What there is in this book is good, but in the interest of an old friend we should like to see it brought more into line with the actual state of our knowledge.

## Medical News.

### The Army Medical Service.

THERE are several vacancies in the higher ranks of the Army Medical Service; but it has been decided (says the *World*) not to take steps to fill them until the arrival in England of Surgeon-General Taylor, the new Director-General, when the whole question of future promotion will be gone into.

### Royal Commission on Tuberculosis.

THE Royal Commission on Tuberculosis, who have accepted Sir James Blyth's generous offer to place at their disposal for experimental purposes two of his farms at Stansted, Essex, will commence work there early in the New Year, the necessary structural alterations now being in hand. The experiments which it is intended to carry out at these Essex farms are expected to occupy about two years, and will extend over a very wide range, and, in addition to all kinds of bovine animals, will include several other species. The risks of infection being spread from the experimental farms are much less than those which attach to the great majority of farms in the country. It is well known that over 20 per cent. of all the cows in Great Britain are already tuberculous, and it is at present difficult to find a large herd of cows entirely free from the disease. Nevertheless, it is highly exceptional to find that any precautions, such as the Royal Commission will employ, are taken to prevent the spread of the disease.

### Royal College of Surgeons of England.

At the last meeting of the Council a unanimous expression of regret was voted in respect of the loss which the College had sustained by the death of the late Sir William McCormac, who had long been so closely connected with the College. The Council decided that it would be undesirable to re-open the question of the election of members of Council by members of the College, and in reference to another resolution it was decided to inform the mover and seconder that the Council would be prepared to give their serious consideration to any draft Medical Amendment Act which should be submitted to them. With regard to the suggested election of the College representative on the General Medical Council by the body corporate it was resolved that as it was essential that the representative should be a member of the Council of the College the election ought to remain in their hands.

### A Physician Sued in Damages for Libel.

THE action in which the Matron of the Belper Isolation Hospital claimed damages against Dr. R. G. Allen for a libel contained in a letter addressed by him to the Managing Committee of that institution was tried at the West Riding Assizes last week, and terminated in a verdict for the plaintiff, with £100 damages. The Judge decided that the occasion was not privileged, and he declared that there was absolutely no foundation for the defendant's statement that he had received more insolence from the plaintiff in six months than he had received in a quarter of a century. We should infer from the evidence that the plaintiff was not the easiest of persons to get on with, but between this and a broad unsubstantiated statement of the kind referred to there is a wide margin. Dr. Allen has our sympathy, and we regret not being in a position to offer him our congratulations.

### A Serious Charge.

MR. JOHN W. AYRES, a Liverpool practitioner, has been committed for trial on a charge of manslaughter. It appears that the accused had occasion to put the deceased out of his surgery, and, on throwing him out, the man fell and, in falling, struck his head against the kerbstone, causing fracture of the skull.

### Beri-Beri at Liverpool.

Two deaths from beri-beri have occurred at Liverpool, the victims being two lascars belonging to the crew of

(a) "Plasmon Cookery Book." Published by the International Plasmon, Limited, London.

(b) "Elements of Practical Medicine." By Alfred H. Carter, M.D., M.Sc., F.R.C.P., Professor of Medicine, University of Birmingham, &c. Eighth Edition. London: H. K. Lewis, 1901. Price 10s. 6d.



s.s. "Pequ." Two others remain in hospital under treatment.

#### The East Ham Indecent Assault Case.

DR. WILLIAM TYNDALE WATSON, who pleaded guilty at the last session of the Central Criminal Court to a charge of indecent assault on a girl, came up for sentence last week, and after medical evidence had been given as to his health the Judge passed a sentence of four weeks' imprisonment, to date from the first day of last sessions, the effect of which was that the prisoner was then released.

#### An Unsolicited Testimonial.

DR. F. W. GRANT, J.P., B.Sc., who was invalided home from South Africa in October, 1900, suffering from chronic dysentery, gives a glowing account of the progress he made towards recovery on a diet almost exclusively made up of Mellin's Food, which was the only food his much enfeebled alimentary tract would tolerate. He emphatically states his belief that Mellin's Food is a "sheet anchor" in stomach and intestinal disorders, as well in the adult as in the infant.

#### Dublin Death-rate.

In the Dublin registration area for the week ending Saturday, December 14th, 1901, the deaths registered represent a mortality of 19.2 in every 1,000 of the population. During the fifty weeks ending with Saturday last the death-rate averaged 25.5 per 1,000. In seven instances the cause of death was uncertified, there having been no medical attendant during the last illness. Thirty-one of the persons whose deaths were registered during the week were infants, of whom twenty were under one year and eleven were under one month of age. The severe weather has produced a rise in the death-rate from respiratory diseases, which group of diseases caused thirty-three deaths during the week.

#### Vital Statistics.

THE deaths registered in the week ending December 14th in 37 large towns of the United Kingdom corresponded to an annual rate of 18.6 per 1,000 of their aggregate population, which is estimated at 11,463,026 persons in the middle of this year:—

Belfast 21, Birkenhead 17, Birmingham 22, Blackburn 11, Bolton 17, Bradford 14, Brighton 17, Bristol 17, Burnley 19, Cardiff 16, Croydon 12, Derby 13, Dublin 17, Edinburgh 20, Glasgow 21, Gateshead 16, Halifax 15, Huddersfield 14, Hull 14, Leeds 18, Leicester 17, Liverpool 20, London 18, Manchester 19, Newcastle-on-Tyne 20, Norwich 20, Nottingham 18, Oldham 24, Plymouth 22, Portsmouth 18, Preston 22, Salford 21, Sheffield 21, Sunderland 18, Swansea 16, West Ham 15, Wolverhampton 16. The highest annual death-rates per 1,000 living, as measured by last week's mortality, were:—From measles, 2.9 in Blackburn, and 5.6 in Norwich; from scarlet fever, 1.0 in Newcastle-on-Tyne; from whooping-cough, 1.0 in Liverpool; and from diarrhoeal diseases, 1.1 in Burnley and in Swansea. In none of the large towns did the death-rate from fever reach 1.0 per 1,000. The 78 deaths from diphtheria included 31 in London, 6 in Liverpool, 5 in Salford, 3 in Brighton, 3 in Portsmouth, 3 in Bristol, 3 in Birkenhead, 3 in Belfast, and 3 in Sheffield. Twenty-six deaths from small-pox were registered in London, and 1 in Birmingham, but not one in any of the other large towns.

Royal College of Surgeons, Ireland, and the late Sir Wm. MacCormac, Bart., F.R.C.S.I.

At a meeting of the Council held on Thursday last, December 19th, the following resolution was unanimously adopted:—"That the president, vice-president, and council desire to convey to Lady MacCormac their profound sympathy with her in her great bereavement, and at the same time to give expression to their appreciation of the irreparable loss which the science of surgery has sustained by the death of their distinguished fellow-countryman, her illustrious husband."

## Pass Lists.

### University of London.

THE following candidates have passed the B.S. Examination:—

First Division.—Janet Mary Campbell, Felix Bolton

Carter, M.D., Arthur Edmunds, B.Sc., Ernest Lewis Lilley, Chas. Archibald Scott Eidout, Thomas Copeland Savage, Ralph Paul Williams, W. Halliburton McMillen. Second Division.—William Fielding Addey, Kenneth Bush Alexander, William Billington, Charles Henry Bullen, Adrian Caddy, Katherine Chamberlain, Carey Franklin Coombs, David Leighton Davies, Herbert Charlton Jonas, Helena Gertrude Jones, Henry Crewe Keates, Robert Kelsall, Herbert James Marriage, Richard Rothwell Mowll, Frank Herbert Noke, William Trethowan Rowe, Douglas Wilberforce Smith, William Lumsden Stuart, Kenneth Vincent Trubshaw, Blanche Elinor Walters, Herbert Septimus Ward, Florence E. Willey, B.Sc., Louisa Woodcock, Edith Louisa Young, Ernest Eric Young.

M.D. Examination Medicine Pass List.—Frederick Holgate Atkinson, Arthur Stanley Barnes, B.Sc., Edward Vipont Brown, Stanley Arthur Bull, Jos. E. Goodfellow Calverley, B.S., Harold Selwyn Capper, Arthur Stanby Cobbleidick, B.S., Maurice Vere Coleman, Albert Ruskin Cook, B.Sc., Percy Robert Cooper, B.Sc., Frank Sherwill Dawe, B.Sc., John Thomas Dunston, B.S., Herbert Lightfoot Eason, B.S., William Norwood East, Jos. George Emanuel, B.S., B.Sc., William Layard Griffiths, B.Sc., John Grimshaw, George Henry James Hooper, Charlotte Elizabeth Hull, B.S., Mary Muriel Griffin Iles, B.S., Frank Harwood Jacob, Harriett Minnie Levick, B.Sc., Donald Johnstone McGavin, Brian Melland, Julius Moore, Winifred S. Patch, B.S., B.Sc., Arthur Robert George Pocock, George E. J. A. Robinson, B.S., Lewis Albert Smith,\* Mabel Geraldine Stevenson, B.S., Walter Hy. Maxwell, B.S. (Gold Medal), Harold John Van Praagh, Ethel Miller Vernon, B.S., William Bertram Watson, Eliza Turner Watts, B.S., William Henry Willcox, B.Sc.

State Medicine.—Francis Seymour Lloyd.

\* Obtained the number of marks qualifying for the Gold Medal.

M.S. Examination, Pass List.—Joseph Faulkner Dobson, Arthur Henry Evans, M.D., Hugh Mallinson Bigby, Philip Turner, B.Sc.

### Royal College of Surgeons, Edinburgh.

At a meeting of the College, held Dec. 16th, the following candidates, having passed the requisite examinations, were admitted Fellows of the College:—John Jackson Berry, L.R.C.S.E., M.D.; Richard Horace Gibbs, L.R.C.S.E.; George William Hardie, L.R.C.S.E.; James Phillips, M.E.C.S.Eng., L.R.C.P.Lond.; William Foster Rawson, M.E.C.S.Eng., L.R.C.P.Lond.; and Alexander Johnston Wilson, L.R.C.S.E.

### Society of Apothecaries of London.

THE following candidates passed at the December examination in:—

Surgery: J. W. W. Adamson (Section I.), A. A. E. Baptist, R. C. Bennett, L. Courtauld (Section I.), W. P. A. Hardwicke, D. V. Muller (Section II.), F. A. Paterson (Section II.), W. G. Rogers (Sections I. and II.), C. W. Smith (Sections I. and II.), W. Thorp (Sections I. and II.), C. Watson (Sections I. and II.).

Medicine: W. Alcock (Sections I. and II.), T. J. M. Clapperton (Sections I. and II.), J. T. Crowe, J. M. King (Sections I. and II.), C. A. Lower (Section II.), D. V. Muller (Section II.), W. G. Rogers (Sections I. and II.), C. W. Smith (Sections I. and II.), W. Thorp (Sections I. and II.), S. C. Wilkinson (Sections I. and II.), J. H. Williams.

Forensic Medicine: T. J. M. Clapperton, W. T. Colyer, G. Cross, J. T. Crowe, W. G. Rogers, C. W. Smith, W. Thorp.

Midwifery: J. H. Clements, K. A. Dawson, A. Dewar, G. Dewick, B. M. Dunstan, H. J. Gater, D. E. T. Griffiths, G. W. C. Hollist, A. Holroyde, C. H. Pring, W. G. Rogers, C. J. Taylor, W. Thorp.

The diploma of L.S.A. was granted to the following candidates, entitling them to practise medicine, surgery, and midwifery:—E. C. Bennett, T. J. M. Clapperton, G. Cross, J. T. Crowe, C. A. Lower, D. V. Muller, F. A. Paterson, W. G. Rogers, C. W. Smith, W. Thorp.

## Notices to Correspondents, Short Letters, &c.

✎ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

DR. STEEDE's paper is marked for early insertion.

MR. C. A. BAILEY.—We regret we have no space for your letter, which is mainly a repetition of arguments and views previously advanced.

DR. MURRELL's paper on "Some Cases of Cirrhosis of the Liver with Ascites, including one of Banti's Disease, &c.," will appear in our next issue.

MINSTREL.—You will find all the required information on reference to our "Educational Number" of September 11th.

PRO PATRIA.—WILLIAM SMYTH.

The following lines were written for the *Westminster Gazette* in memory of Dr. William Smyth, the "medical hero," (a record of whose heroic deeds and tragic death first appeared in the columns of the *MEDICAL PRESS AND CIRCULAR*), of Burtonport, Donegal, who fell a victim to his self-devotion in saving the typhus-stricken on Aranmore Island:—

There is a picture I would paint for you,  
Just as I seem to see it, night and day.  
Because I know those wilds of Donegal,  
That are so lovely in their loneliness—  
So terrible, so grimly desolate;  
Because I love the people and their ways.  
Above its coast there lies a lonely isle  
Unnoted in a solitary sea,  
But not unmarked by Death, who swings his scythe  
About the cabins, harvesting the poor.  
Late, a great terror on the people fell  
Of the old fever and the new-made graves,  
So from the sick they shut themselves away,  
And they were left to moan beneath the thatch,  
Unnursed, unhelped, unheeded, save by one;  
Now this man, look you, had a wife at home,  
And eight young children, whose soft-clinging arms  
Were links of love to bind him to the land,  
And yet he set his face to the grey sea,  
Under a low sky burning stormy red,  
Like to the smouldering fire of his doom.  
I think the shining stars have never smiled—  
Nor the sweet Presences that walk unseen  
Noting white records to redeem the world—  
U, on a nobler sight than that lone boat  
Facine the elemental forces, Wind and Wave,  
Fronting the phantom eyes of Death and Fear.  
So every day that Healer went and came,  
But when his utmost skill of brain and heart  
Could hardly save the sufferers where they lay,  
With his own hands he laid them in his boat,  
And, no man aiding, rowed them to the land  
Where blew the breath of life and they were saved;  
Then fell the fever on him, and he died.  
But since he died for men I hold he leaves  
In a perpetual legacy to us,  
A sacred charge and memory—his name—  
That none shall be more honoured under Heaven;  
His children; that we see their lives shall grow  
Worthy the fashion of their father's death.

L. M. LITTLE.

DEPUTY-CORNER.—The most reliable, at the same time the most succinct, guide for *post-mortem* examinations and the preparation of specimens with which we are acquainted will be found in the new edition of Delafeld and Prudden's "Handbook of Pathological Anatomy."

THE CRIME OF VIVISECTION!—A CHRISTMAS CAROL.

A CORRESPONDENT, whose signature has appeared under letters in these columns in a discussion on "The Biological Test," has received the following Christmas greeting on a postcard:—"SIR,—Anent the crime of vivisection it is written: Those who seek to save their lives in this world will lose their souls in eternity. Vivisection is a blasphemous crime which has no forgiveness. We cannot serve two masters. Vivisectioners are working out their own damnation, and those who are weak enough to hobnob with them here will be obliged to dwell with them hereafter!" Needless to add, the writer of this eminently charitable and characteristic opinion has not the courage of his name.

## Appointments.

BOAG, JAMES, M.B., M.S. Glasg., Certifying Surgeon under the Factory Acts for the Wishaw District of Lanarkshire.  
CHEATLE, GEORGE LENTHAL, C.B., F.R.C.S., Surgeon to the Italian Hospital, Queen Square, London.  
COATES, C. M., L.R.C.P. Edin., L.R.C.S. Edin., Certifying Surgeon under the Factory Acts for the Creech St. Michael District of Somerset.  
CUDMORE, ARTHUR MURRAY, M.B., Ch.B. Adel., M.B.C.S. Eng., Honorary Assistant Surgeon to the Adelaide Hospital, Australia.  
DEANE, ANDREW, M.D., F.R.C.S. I., Lieutenant-Colonel, I.M.S. (retired), Superintendent to the Royal Victoria Hospital, Belfast.  
HIND, WHEELTON, M.D. Lond., F.R.C.S., Senior Honorary Surgeon to the North Staffordshire Infirmary and Eye Hospital.

JOHNSTON, S. E., M.B., C.M. Edin., Assistant Resident Medical Officer to St. Mary's Hospital for Sick Children.  
PARKE, T. H., M.B.C.S., L.R.C.P. Edin. Certifying Surgeon under the Factory Acts for the Tideswell District of Derbyshire.  
PEREIRA, JOSEPH ANTHONY WENCZSLAUS, L.R.C.P. Lond., M.B.C.S., Medical Officer to the Exeter Workhouse.  
POOLER, EDWARD LESLIE, M.D. R.U.I., L.K.Q.C.P.I., Medical Officer to the Destitute Poor and Aborigines of the District of Stirling, South Australia.  
ROGERS, F. C., F.R.C.S.E., L.R.C.P.E., Medical Officer of Health to the Erith District Council.  
STANTON, W. D., F.R.C.S. Edin., Honorary Consulting Surgeon to the North Staffordshire Infirmary and Eye Hospital.  
WORGER, R. G., M.B.C.S., L.R.C.P. Lond., L.S.A., Surgeon under the Factory Acts for the Radstock District in the County of Somerset.

## Vacancies.

Bethnal Green.—Nurse for four months for an East London parish. Liberal emolument and bonus offered. Address, Nurse Lillian, 9, Green Street, Bethnal Green, London, E. (See Advt.).  
Birmingham General Dispensary.—Resident Surgeon. Salary £150 per annum (with an allowance of £30 per annum for call-hire), and furnished rooms, fire, lights, and attendance. Applications to Ernest W. Forrest, Secretary.  
Devonshire Hospital, Buxton, Derbyshire.—House Surgeon and Assistant House Surgeon. Salary, House Surgeon £100 per annum, Assistant House Surgeon £50 per annum, with furnished apartments, board, and lodging in both cases. Applications to the Secretary.  
Jaffray Branch of the General Hospital, Gravelly Hill, near Birmingham.—Resident Medical and Surgical Officer. Applications to the House Governor.  
Kidderminster Infirmary and Children's Hospital.—House Surgeon. Salary commencing at £140, with rooms in the Infirmary and attendance (option of board at £40 per annum). Applications to the Secretary.  
Lanark County Asylum, Glasgow.—Third Assistant Medical Officer and Pathologist. Salary £120 per annum, with board, residence and washing. Applications to the Medical Superintendent at the Asylum, Hartwood. (See Advt.).  
Mercer's Hospital.—Resident Medical Officer. Applications, with testimonials, to the Registrar, John Robinson. (See Advt.).  
Norfolk County Asylum, Thorpe, Norwich.—Junior Assistant Medical Officer. Salary begins at £120 per annum, with board (no liquors found), lodging, and washing. Apply to the Medical Superintendent.  
South Devon and East Cornwall Hospital, Plymouth.—House Surgeon. Salary £100, with board and residence. Applications to Hemsley H. Shanks, R.N., Hon. Secretary.  
St. Bartholomew's Hospital.—Surgeon (Honorary). Candidates must be Fellows of the Royal College of Surgeons of England. Applications to Wm. Henry Cross, Clerk.  
St. Thomas's Hospital.—Resident Assistant Physician. All necessary information can be obtained on application at the Hospital, Westminster Bridge.  
Sunderland Infirmary.—House Surgeon. Salary commencing at £100, with board and residence. Applications to the Secretary.  
Whitechapel Union Infirmary.—First Assistant Resident Medical Officer. Salary £130 per annum, with board, furnished apartments, coal gas, and washing. Forms of application may be obtained of the Clerk to the Guardians, Union Offices, Whitechapel, N.E.  
Waterford District Asylum.—Assistant Medical Officer. Salary £100 per annum, with board, washing, and attendance. Applications to the Resident Medical Superintendent. (See Advt.).

## Births.

BROOKE.—On Dec. 17th, at Bedland's Nook, South Holmwood, Dorking, the wife of Frederick Brooke, M.B.C.S. Eng., L.E.C.P. of a daughter.  
HAYMAN.—On Dec. 15th, at Thorncliffe, Clapham, Park, the wife of William Speed Hayman, M.B., of a daughter.  
MARTIN.—On Dec. 20th, at Clifton House, Bermondsey, S.E., the wife of F. G. Clifton Martin, L.R.C.P. Lond., M.B.C.S. Eng., L.S.A. Lond., of a daughter.  
NASH.—On Dec. 16th, at Oakfield House, Accrington, the wife of Elwin H. T. Nash, M.B.C.S., L.E.C.P., of a son.  
SUTHERLAND.—On Dec. 17th, at 32, George Square, Edinburgh, the wife of L. B. Sutherland, M.B., C.M., of Dundee, of a daughter.

## Marriages.

BATTY—ROY.—On Dec. 17th, at St. Peter's, Southborough, James Henry Batty, of the Gold Coast and London, to Violet, widow of the late Professor Roy, F.R.S., and daughter of the late Sir George E. Paget, K.C.B., F.R.S., of Cambridge.  
JACKSON—PAGET.—On Dec. 17th, at St. Andrew's Church, Derby, Richard Houlton Jackson, F.R.C.S., L.R.C.P., eldest son of John Houlton Jackson of Longridge Road, London, to Rose May, eldest daughter of the late Arthur Paget and Mrs. Paget, of Badmoor, Loughborough.

## Deaths.

BRABAZON.—On Dec. 18th, suddenly, the Rev. R. C. Brabazon, third surviving son of the late A. B. Brabazon, M.D., Bath.  
DAY.—On Dec. 20th, at Harlow, Essex, Sarah Ann Day, widow of Robert Newcombe Day, aged 72.  
ELLERMAN.—On Dec. 18th, at Rotherfield, from a cycle accident, Clarence Ellerman, M.D., in the 38th year of his age.  
GILBERT-SMITH.—On Dec. 19th, at 68, Harley Street, Cavendish Square, Olga Mary, the beloved and only daughter of Dr. and Mrs. Gilbert-Smith, aged 29.

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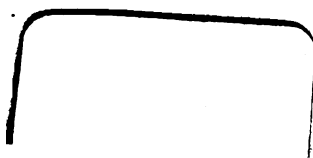
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